Xifin CEO: Time to tune up negotiations with payers

Sherrie Rice

September 2018—The second round of PAMA data collection is coming in 2019 and it's critical to get it right, said Lâle White, CEO of Xifin, in a presentation in May at the Executive War College. If it's not right, she warned, laboratories could see cuts that are more severe than those already seen.

In the first round of cuts, the rates for 75 percent of all codes on the clinical laboratory fee schedule decreased, while 10 percent of rates for codes on the CLFS increased. With a $3.6 billion savings expected over three years, "the level of cuts was essentially almost double what the Office of Management and Budget and the Congressional Budget Office anticipated," White said, noting that PAMA affected Medicaid as well as Medicare, with some states feeling a greater impact. "One of the things we have to do is work with the Medicaid programs to make sure access is not lost in some of these states," she said.

Nursing home laboratories will see a 9.44 percent cut in total by 2020. "They are probably the most affected labs," White said. Least affected are pain and pharmacogenetics testing labs with a 0.15 percent cut by 2020, and molecular testing labs, at 0.31 percent. "These labs have also had severe price cuts on their own in the past several years, but they will have almost no impact with PAMA, and there will be some stability in pricing for these sectors."

Clinical laboratories will see a 5.33 percent decline by 2020, and pathology labs a 4.07 percent decline.

"Over 90 percent of the PAMA data came from independent clinical labs and only two percent from hospital labs," which, she said, is the basis of the ACLA lawsuit. "They're seeking an injunction in order to change the way this exercise was performed."

Three dozen groups representing patients, health care professionals, laboratories, and diagnostic manufacturers, including the CAP, urged Congress to reform PAMA. In an Aug. 2 letter sent to congressional leaders, they wrote, "In a medical age where technology is pushing closer to patients, the bureaucratic policies implemented through PAMA will drive care and the promise of better health further away from patients."

They asked Congress to modify PAMA to address data integrity concerns and market exclusion, ensure that the private payer data the Centers for Medicare and Medicaid Services collects accurately represents all segments of the market, and provide a transparent process to allow for validation of the data CMS collects.

Lessons learned on the first go-around need to be applied to the second, White said at the War College, including understanding the accuracy of the data submitted and making sure they are auditable and there is source documentation. Also important: understanding the errors payers make in explanations of benefits that cause labs to submit improper or incorrect pricing that affects some of the reimbursement levels. "Strong financial systems are key to this exercise," White said.

Laboratories also need to understand "how to talk to payers and how to approach them about the fee structure itself."

"Many labs that truly understand the value of their tests and that have calculated the incremental and fully loaded cost of each of their tests are able to negotiate different types of rates at different percentages of Medicare for their routine services versus their esoteric and genetic services." Payers seem to understand, White said, that the market value of the Medicare fee schedule is not realistic and that negotiations on different types of testing become important in the process to establish fees.

White

“Essentially we’re looking at market value and market value pricing. We need to make sure we understand what the cost of all of our tests are, and we need to establish a standard fee that’s not just a fee that is a percentage over Medicare, or over your highest payer, but that’s proportionally aligned with the costs of the tests being performed. And we need to be able to negotiate off of this type of fee schedule.”

Many independent and hospital laboratories in the past two years have been successful in negotiating away their contracts that are tied to the current Medicare fee schedule, White said, adding that payers understand that tying rates to the fee schedule will cause a downward spiral. “They’ve been receptive to altering the way they market against current fee schedules. And those that are tied to the Medicare fee schedules have fixed the fee schedule at the 2017 rate and are negotiating off of that.” Not ideal, she added, because even the 2017 rates are not truly market based.

“We have to identify all of the private payer pricing we’re getting that’s below cost, or at an unsustainable level, and renegotiate those areas very well with the payers.”

Coverage is one of the biggest problems now, she said, with payers having spent a lot of time “figuring out how not to pay us.” Laboratories can negotiate coverage criteria too: “Who knows better than the lab performing the test under what circumstances the test should be ordered?”

At the same time, helping physicians with decision support is critical, White said, as is patient pricing transparency.

The changes in reimbursement are leading to other changes in the lab testing industry. For independent laboratories, one is that investor funding is improving for specialty labs with limited menus or proprietary assays. “Investors were sitting on the sidelines” when they were trying to predict the reimbursement structure, White said. “Now that they know, we’re seeing investment come back in. That means more molecular, proprietary testing labs resurface and specialty labs”—cardiovascular, pain, pharmacogenetics, genetics—“come into play.”

“Even as this pricing was coming into play, we saw a lot of labs specializing in specific disease types, and we’ll see that specialization trend continue,” she said. And physicians will continue to partner with specialty labs, mostly to keep pace with new tests. “Specialty labs really assist in that process of optimizing the physician’s order.”

The number of independent labs offering standard test menus will continue to decline, “because that type of testing is the lowest-margin testing.”

In addition, consolidation, partnerships, and joint ventures will continue.

- “Labs with high Medicare and Medicaid mixes in rural areas and nursing home labs will probably cede a lot of that market to regional hospital outreach labs” with better margins.
- Reference labs performing esoteric testing will continue to leverage their economies of scale to partner with outreach laboratories.
- Industry consolidation in routine testing will accelerate “because labs will need economies of scale to support the new cost structure and new reimbursement structure.”

- Independent labs will “move more and more to create joint ventures with hospital labs.”

Hospitals have a big advantage in the new environment, White said. Ninety-two percent operate their own lab; three-quarters of them have an outreach program. The latter is “essential to the hospital lab’s cost structure. They have higher margins and can gain some of this market at a better cost than independent clinical labs” in some of the rural areas with large Medicare populations.
Hospital laboratories themselves have financial advantages.

“Their in-network status is excellent,” she said. They have most, if not all, of the payer contracts within a region, and physicians prefer to use a single laboratory rather than multiple labs. Reimbursement rates are significantly higher than for independent laboratories. (Patient copays are higher too, White noted, but the in-network status mitigates that in some ways.)
“We also see that as laboratories shift their menus to more specialization, hospitals will be able to absorb more of the routine testing in their regions at a better cost margin.”

MACRA will continue to drive physicians to the hospital for population health management so they can report their quality metrics and obtain reimbursement, White said. “So hospital labs have a ready-made population of physicians for ordering laboratory tests.”
For hospitals, the limited menu of outreach labs is a disadvantage, but a wide and diverse menu can be achieved with complementary partnerships. Fewer phlebotomy centers is another disadvantage, but here, too, partnerships (with pharma chains, for example) help. Outreach’s higher cost structure is a drawback but one that can be modified with outreach development. And “the inadequate financial systems within hospitals are all being upgraded now in the laboratory sector,” White said.

In addition to capturing more revenue with stronger financial systems, White sums up the strategies laboratories can use to offset the impact of PAMA:

- Diversify the test menu and expand specialty testing capabilities.
- Use workflow automation to remove clerical decision-making and achieve labor efficiencies.
- Reduce the total cost of billing to below four percent while achieving bad debt targets.
- Leverage the hospital to negotiate better lab pricing.

“It’s important for us as an industry to understand that the fee schedules are so far outdated that we have to tune up our negotiating tactics with payers as we move forward,” White said.

Sherrie Rice is editor of CAP TODAY.