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PART 2

Applying a Value-Based Model to Lab Outreach

PART ONE of this series appeared in ***MLM***, October, 2015, and outlined success strategies and opportunities for laboratory outreach programs.

Laboratory outreach programs face daily challenges emanating from competing facilities, regulatory and insurance issues, consumer (patient) choices, and the ongoing pressure to justify laboratory's value to senior leadership. Part Two of this series examines how the evolution to a value-based payment model is impacting laboratories and ultimately may necessitate entirely new systems and metrics to demonstrate the laboratory's value within the health system.

Laboratory Outreach Competition

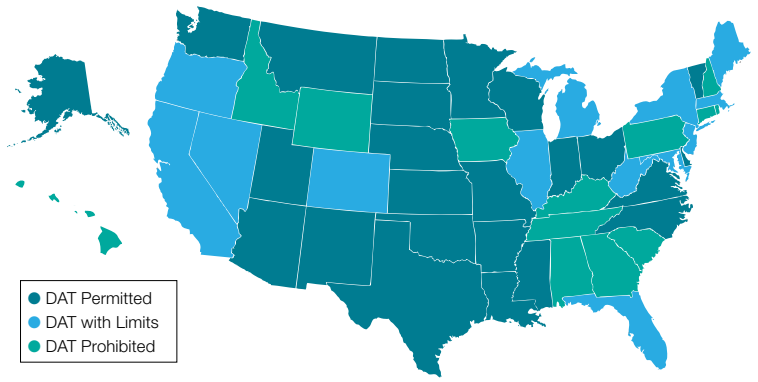
Historically, the success of outreach programs depended upon developing healthy relationships with customers, having an effective business and operational infrastructure, and providing excellent customer service and high quality laboratory testing. These elements tended to be sufficient for labs to establish and enjoy a successful, prosperous business. However, today the types of competition faced by hospital laboratory outreach programs are more varied and complex. To clarify, competitors may be categorized as horizontal, substitute, or vertical:

- *Horizontal* competitors are similar competitors; they provide an equivalent product at a similar price. This category includes other hospital-based laboratory outreach programs located in the same community or region.
- *Substitute* competitors are those that provide a similar service, but deliver the service in a different manner, typically at a lower price. This category includes national or independent laboratories that provide a similar product via a different business model and process.
- *Vertical* competitors are those that impact the profitability (contribution margin) of the laboratory. Increasing in prevalence, these competitors include commercial insurance payors (health plans) that are decreasing the rates they will pay for laboratory services.

In response to the first two of these three competitors, it is relatively easy to define the competing laboratory and establish a corresponding strategy to secure or protect a position within the market. Responding to a vertical competitor is more problematic, as this is not a typical competitor; rather it is a business process that inhibits laboratory outreach success. The challenge occurs when the hospital-based laboratory outreach program is not in a position to engage in effective health plan contracting.

FIGURE 1

Direct Access Testing (DAT) in the US by State



Source: Survey of Direct-to-Consumer Testing Statutes and Regulations, June 2007: Genetics and Public Policy Center, Berman Institute of Bioethics, Johns Hopkins University.

The Three Soft Cs

The dynamics of US health systems are changing the way laboratory outreach programs practice and compete. Health systems are forming and expanding at a rapid pace, with competing hospitals often merging or being acquired by larger organizations; hence, laboratories that once competed may find themselves health system partners.

In the past, independent physicians selected a hospital-based laboratory outreach program's services based on the three soft Cs:

- Community (admitting privilege)
- Continuity (medical record)
- Convenience (service)

This approach typically favored the local hospital outreach program and provided them with a competitive advantage. But, as discussed in Part One of this series, a health system's purchase of physician practices can shift the focus of the lab from outreach to

inreach. The health system often dictates the community, leaving clinicians no choice as to laboratory providers. If the pre-existing hospital outreach program belongs to the parent health system, this stabilizes the customer relationship. Conversely, if the laboratory is unaffiliated, it is likely that it will lose a customer.

The Three Hard Cs

As physician practices have become more technologically advanced and patients have become savvy customers, there has been an evolution to hard selection criteria. The three C's are now:

- Connectivity (information technology/electronic medical record [EMR] interfaces)
- Contracts (health plans)
- Consumer (patient choice and cost)

Regardless of the physician's business relationship with a health system, these criteria weigh heavily on the selection of, and satisfaction with, laboratory services.

The first C, connectivity, offers workflow advantages for the physician office via electronic transmission of orders and results (see **TABLE 1**). Many organizations are able to support this functionality by providing in-office access to the electronic health record or by interfacing with the practice's EMR. Effective connectivity provides a contiguous and longitudinal medical record that reflects a patient's continuum of care within the health system. Some organizations may not have a refined information technology infrastructure that supports electronic ordering and resulting; hence, a provider may insist on using an incumbent or interfaced laboratory until adequate information technology support from the affiliated health system is in place.

TABLE 1
Sources of Outreach Assistance

External Courier Services	
Courier Express	www.courierexpress.net
Medical Courier Elite	www.medicalcourier.com
MNX Global Logistics	www.mnx.com/about_home.aspx
Outreach Software	
Atlas Medical	atlasmedical.com
CareEvolve	www.careevolve.com
Lifepoint Informatics	www.lifepoint.com
McKesson Lab	www.mckesson.com/laboratory
Billing Services	
APS Medical Billing	apsmedbill.com
ARx/XIFIN	www.xifin.com
Kellison and Company	www.kellison.com
Laboratory Billing Solutions	www.laboratorybilling.com
McKesson	www.mckesson.com/bps/pathlab
Psyche Systems	www.psychesystems.com
RCM Medical Billing	www.rcmmedicalbilling.com
Telcor	www.telcor.com
Test Catalog Providers	
ARUP Laboratories	www.aruplab.com
Mayo Medical Laboratories	www.mayomedicallaboratories.com
Lab Outreach Consultants	
Applied Management Systems	www.aboutams.com
Chi Laboratory Solutions	www.chisolutionsinc.com
Huron Healthcare	www.huronconsultinggroup.com
LabMetrics	www.labmetrics.com
Mayo Medical Laboratories	www.mayomedicallaboratories.com
Nichols Management Group	www.nicholsmanagementgroup.com
Logistics	
Medspeed	www.medspeed.com

Health Plans and Patient Choice

With recent changes in the US health insurance market, the other two C's, contracts and the health care consumer, pose significant obstacles for health system-based laboratory outreach programs.

In the past, insurance companies leveraged a variety of restrictions to help control costs. But as a result of the Patient Protection and Affordable Care Act (PPACA) (see **A SIDEBAR ON PAGE 14**), these practices are now banned; insurers can no longer compete by covering only healthy individuals or by reducing benefits and raising deductibles. An emerging trend is the use of narrow networks, which limit provider choice and levy financial penalties on members who use services outside the restricted network. These financial penalties include high co-insurance or a high co-payment or even non-payment for services provided by an out-of-network provider.[1]

When selecting public exchange products, over 80% of purchasers indicate that premium and out-of-pocket costs (ie, deductible, co-payment, co-insurance) are either very or extremely important.[2] In contrast, only about 60% indicate that choice of provider and range of benefits are very or extremely important.[2] Many people who purchase insurance products on the public exchange select the plans with lower up-front premiums and higher deductibles, co-pays, or co-insurance, which require substantially higher out-of-pocket expenditures when a person seeks care. For relatively healthy patients who do not require frequent medical treatment, this may be an acceptable solution. For many, the result is simply that the increased out-of-pocket costs cause them to become more conscious of their health care spending and look for

lower cost service providers, including laboratory testing.

However, the potential repercussions from this situation can be devastating. Deductibles for at least 40% of non-group enrollees are costly at $1,500 for individuals and $3,000 for families.[2] These amounts must be spent before insurance benefits begin. For some, an unexpected expense of $1,500 may not create a financial hardship. However, when health care consumers were asked how they would pay for an unexpected medical bill of $1,500, only 31% indicated that they would be able to pay it immediately; 43% would accrue personal debt, and 15% would not be able to pay at all.[2] Hospital-based laboratory outreach programs may be impacted through increased patient or physician complaints about laboratory bills, and the laboratory may experience an increase in bad debt. If a laboratory is unable to provide competitive access to health plans at affordable out-of-pocket costs, patients may seek lower-cost testing alternatives.

Market Disruption

As clinical laboratories search for ways to compete in the new health care reimbursement system, they must be cognizant of alternate market forces competing for the same market, consumers, and health care dollars. Such disruptive innovation is impacting health care in two ways. First, it prompts many facilities to transfer skills from highly trained and expensive personnel to more affordable providers (mid-level practitioners) or to leverage technology-based care models (eg, telemedicine). Second, it is shifting the provision of care away from traditional health care venues, such as hospitals, into clinics, office settings, and, in some cases, patient homes.[3]

Specific to the clinical laboratory, innovative disruptors are changing the ways in which patients utilize laboratory services, including the specimen collection process (eg, how, when, and where), testing technologies, and the delivery of results.

Retail Access

As innovators seek alternate locations for health care delivery, retail clinics (also called rapid clinics) are opening across the US. Retail clinics are usually situated in convenient locations and often serve patients through national pharmacy chains, grocery and retail stores, private organizations, and sometimes within traditional health care system. Because laboratory results frequently are required for diagnosis, these retail clinics are becoming relatively large users of point-of-care (POC) tests, clinical chemistries, and immunoassay laboratory tests.[4]

Direct-to-Consumer Testing

In addition to retail clinics, another growing trend affecting the clinical laboratory marketplace is direct-to-consumer testing or direct access testing. This type of testing is typically characterized by the consumer paying up-front and out-of-pocket for the service. Tests are usually purchased without physician consultation, and the patient is responsible for any follow-up with their health care provider. Within the US, only 13 states still require a doctor's order for laboratory testing; 26 states and the District of Columbia allow patient-directed testing for any test, and 11 states permit patient-directed orders for a limited test menu (see **FIGURE 1**).[5,6]

Numerous commercial companies, independent laboratories, and health care organizations have responded to meet this consumer demand. Delivery models vary, ranging from specimen collection and testing performed on-site, to traditional patient service centers that collect and forward specimens to accredited laboratories for testing. Advocates of patient-directed testing highlight the empowerment patient test ordering affords today's educated and demanding health care consumers.[7] This approach can provide price transparency, affordability, access to results, and increased engagement and ownership by the patient.

Leadership Support for the Lab

In addition to the external pressures from competitors, health plans, and consumers, laboratories frequently face pressures within their institutions. While we know the role of laboratory

SIDEBAR

A Snapshot of the Patient Protection and Affordable Care Act

The health care spending crisis in the US led to the passage of the Patient Protection and Affordable Care Act (PPACA), which represents an effort to reframe the way health care systems pay for services. Instead of basing payment on volume, under the PPACA, payment is based on value. The PPACA strives to provide health insurance for all Americans and begins the process of realigning the health care system for long-term change by rewarding quality, effective practice design, and health information transparency. By creating public health insurance exchanges, the PPACA simplifies health insurance purchasing with a one-stop shopping market for insurance products that qualify for federal tax subsidies. Many of the products on the exchange are part of a tiered system (ie, bronze, silver, gold, platinum, and catastrophic). The level of coverage and percentage of patient responsibility (ie, out-of-pocket costs) are determined by the consumer's choice of tier. Higher-tiered plans have higher premiums and lower out-of-pocket patient responsibility, while lower-tiered plans have lower premiums and higher patient out-of-pocket costs. Individuals enrolling in the health plans offered on the Federal Marketplace tend to select the bronze (20%) and silver (65%) options, which pay only 60% and 70% of costs, respectively.*

* American Hospital Association. Trendwatch: Increasing consumer choice in coverage and care: Implications for hospitals. June 2014. http://www.aha.org/research/reports/tw/14june-tw-consumerchc.pdf. Accessed January 4, 2016.

testing is valuable, demonstrating that value to organizational leadership is an ongoing challenge.

In a fee-for-service reimbursement environment, the transactional nature of the laboratory business has historically led to a focus on volume and analytic quality. Standard business-related measures of laboratory success include test volumes, staffing metrics, net revenue, cost per test, and outreach program profitability. Standard service-related measures include turnaround time, telephone response time, on-time courier service, patient wait time, and error rates for data entry and billing. Clearly, it is necessary to monitor and report relevant metrics and use industry or peer benchmarks when appropriate.[8]

However, with the national trend toward value-based payment systems that reward quality and outcomes, the standard metrics may no longer adequately demonstrate the value of the laboratory. Bundled payment models are emerging as a new reality in health care, and in such models, laboratory testing is considered a cost, rather than an income source. Thus, value must be created and demonstrated in a different way. In early 2015, the Department of Health and Human Services announced their goal to tie 30% of traditional (fee-for-service) Medicare payments to quality or value through alternative payment models by the end of 2016, and 50% of payments to these models by the end of 2018.[9] Payments for laboratory services will be included in these bundled payments.

In order to compete in a value-based reimbursement environment, the laboratory must adjust its mindset to one of creating value. It is commonly accepted that 70% of all medical decisions depend on laboratory data.[10] We have the opportunity to leverage laboratory results as actionable data that can affect costs and outcomes across the entire health care system. This begins with shifting from a cost-per-test mindset to an aggregate cost mindset, where a laboratory result is not a commodity, but rather a key diagnostic tool that impacts the total cost of patient care. Certainly, this message is not easily conveyed via standard performance management reports provided to hospital administration. Administrative leadership may require education and enhanced performance reports that depict the true value of the laboratory.

Managing unit cost will always be important; however, in the future, it will be more appropriate to demonstrate how, with proper utilization, a laboratory result can aid in managing diagnostic and treatment costs, positively contributing to downstream costs, quality, efficiencies, and outcomes.

Conclusion

The laboratory industry and outreach programs in particular are not immune to the changes that are reshaping health care in the US. Challenged by traditional and emerging competitive threats, consumerism, disruptive business models, and changing systems of payment, laboratories must remain vigilant and nimble in their response to change. ■

PART THREE of this series will outline survival strategies for hospital-based laboratories and their outreach programs, including ways to align with nationally accepted systems of care and demonstrate the role that laboratory outreach programs play in establishing the enduring value of laboratory testing.

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