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From the Desk of R. Lewis Dark...

THE DARK REPORT

RELIABLE BUSINESS INTELLIGENCE, EXCLUSIVELY FOR MEDICAL LAB CEOs / COOs / CFOs / PATHOLOGISTs

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R. Lewis Dark

Founder & Publisher

Laboratory Regionalization Enters a New Phase

REGIONALIZATION OF LABORATORY SERVICES has been the primary theme behind all major changes to the clinical lab industry since the mid-1980s. There have been several phases, such as commercial lab consolidation, and hospital lab consolidation. But a constant factor underlying each of these phases has been the increased regionalization of lab services.

THE DARK REPORT is again first to identify and report on a new market cycle for the lab industry. As you will read on pages 6-8, our Editor-In-Chief, Robert Michel, predicts that the next phase of change will be the emergence of shared laboratory service organizations. This time, it will be primarily integrated healthcare networks (IHN) which come together and form a laboratory joint venture.

Since most IHNs have already consolidated laboratory services within their system, the continued need to reduce costs while acquiring expensive new diagnostics technology will motivate IHN CEOs to approach their counterparts across town to create a lab services joint venture. Our story on **Spectrum Laboratory Network** in Greensboro, North Carolina **(see pages 4-5)** is one such example of a multiple-IHN laboratory joint venture.

I agree with Robert Michel's prediction. Economic pressures to squeeze out more costs while investing in new diagnostics technology will continue to tax the budgets of most hospital laboratories. Excess and unused hospital lab capacity in every city must be either removed or utilized. The financial survival of all types of clinical laboratories will continue to depend on continually improving productivity. I believe the effort to support improved laboratory performance that was launched by the **Premier, Inc.**, the national GPO, in 1998 is grounded in the same understanding of healthcare market principles as Michel's prediction.

In fact, even as he was working on this first draft of his story, the fax machine turned on and delivered the press release announcing that the 12-hospital **Aurora Health System** in Milwaukee and the 8-hospital **Advocate Health Care** system in Chicago would merge their lab organizations. Talk about timing! It was the marketplace validating the very prediction that was in his word processor! For my money, it again demonstrates that THE DARK REPORT has a very capable prognosticator gathering up-to-the-minute business intelligence for our members. TDR

Consolidated Med Labs Prepares To Close Down

Long-standing lab joint venture will cease operations on Thursday, June 1

CEO SUMMARY: One of the clinical lab industry's most successful for-profit joint ventures will close its doors after 20 years of operation. The demise of Consolidated Medical Laboratories again demonstrates how difficult it is to overcome the different political agendas of hospital partners. Strong financial performance is frequently not enough to motivate hospital administrators to continue such laboratory joint ventures.

EVEN HEALTHY PROFITS and happy physician-clients were not enough to keep **Consolidated Medical Laboratories** (CML) open and in business.

Based in Lake Bluff, Illinois, CML will close its doors for good on June 1, 2000. The closure is a direct result of the acquisition, by **Evanston Northwestern Healthcare** (ENH) of **Highland Park Hospital**, one of the two partners in the CML joint venture, and ENH's desire to integrate its hospital lab services

"It's an unfortunate situation," said Matt Hamlin, Executive Director at CML for the past four years. "Financially, 1999 was our best-ever year. And in each of the past four years, we've steadily increased revenues. CML closes at the height of its business and service success."

The two owners of Consolidated Medical Laboratories are Highland Park Hospital and **Lake Forest Hospital**. Located about eight miles apart, they compete intensely for patients.

When Evanston Northwestern Healthcare merged with Highland Park Hospital on January 1, 1999, it changed the competitive situation between CML's two partners. Evanston operates a consolidated laboratory system which services its integrated health system, including three hospitals and affiliated physician practices. Evanston obviously wanted to bring Highland Park's lab testing into its consolidated lab system.

"After much discussion, Lake Forest Hospital decided that it wanted to maintain control over its own laboratory testing," noted Hamlin. "As a

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result, it is already preparing to expand testing performed within its own lab.

"Meanwhile, CML is preparing for a total shut down," he explained. "On June 1, we will close our offsite core lab and terminate services to our clients. Letters were sent to all clients notifying them of the need to make other arrangements for their lab testing needs."

CML's shutdown leaves a service vacuum for physician clients located in medical buildings on the campuses of the two hospitals. Within this service area, for at least 10 years CML enjoyed a market share approaching 90%.

Intense Sales & Marketing

Evanston's lab organization is marketing heavily to CML clients. **Quest Diagnostics Incorporated** also spotted the opportunity to capture new business. Intense sales and marketing between the two labs is ongoing.

Because these physicians were strongly loyal to CML, it will be tough for both Evanston and Quest Diagnostics to match the service provided by CML. As noted by THE DARK REPORT in past years, physician loyalty to CML was so strong that most major HMOs had to carve CML out of their national contracts.

For example, when the national **Cigna Healthcare** contract went to **SmithKline Beecham Clinical Laboratories** (SBCL) in 1995, doctors around the Highland Park and Lake Forest medical office campuses insisted that CML be made a provider. Cigna agreed, and allowed CML to provide testing under a fee-for-service arrangement.

One interesting aspect to the closure of CML involves the pathology arrangements. The same pathology group served both hospitals. With Highland Park Hospital becoming part of the Evanston Northwestern Healthcare System, six pathologists from the group practice have chosen to sign a contract with Lake Forest Hospital. They will also do work for Quest Diagnostics.

The demise of Consolidated Medical Laboratories is unfortunate. It was created in 1980 when Lake Forest Hospital and Highland Park Hospital formed a for-profit laboratory partnership. Both hospitals were served by the same pathology group, which saw the benefits from eliminating duplication The two hospitals, located about eight miles apart, were, and continue to be, ardent competitors.

During the past 20 years, CML achieved a strong reputation among doctors in its service area. THE DARK REPORT considered it to be an excellent example of how two intensely-competitive hospitals could still cooperate to share laboratory services.

There are probably two relevant lessons to be drawn from the experience of CML. One, it is possible for competing hospitals to collaborate, on a long-term basis, with shared laboratory services that include a profitable outreach testing program.

Economic Benefits

Two, the politics and market dynamics between competing hospitals can still outweigh the economic benefits that come from a laboratory joint venture. The need to control the total aspect of a hospital's clinical activities seems to be a stronger motivation than all the service enhancements and financial benefits that accrue from a successful laboratory joint venture.

Finally, the intense loyalty which physician clients directed toward CML is an important reminder for all hospital administrators. Every well-managed hospital laboratory outreach program has a strong competitive advantage in its selected service area over commercial laboratory competitors. CML is just one example of this industry-wide management truth. TDR

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Spectrum Labs Selects Nate Headley To Be CEO

Former PCL & NHL executive leaves California for North Carolina laboratory

CEO SUMMARY: Spectrum Laboratory Network, a joint venture among several large hospitals, recently selected Nate Headley to be its new Chief Executive Officer. Since its launch in 1997, Spectrum has performed below the expectations of its hospital owners. It was to enhance laboratory services to the hospitals, while generating additional cash flow by expanding specimen volume from outreach testing.

TO FULFILL ITS SEARCH for a new chief executive officer (CEO), **Spectrum Laboratory Network**, based in Greensboro, North Carolina, decided to reach all the way into California.

Spectrum announced on April 10 that Nate Headley would be its new CEO. Spectrum Laboratory Network is a joint venture owned by three hospitals, **Forsyth Memorial Hospital**, **Moses H. Cone Memorial Hospital**, and **High Point Regional Health System**.

Emerging Business Model

Spectrum Laboratory Network is an example of a laboratory business model that will become increasingly common. Competing hospital operators in the Greensboro/Winston-Salem area came together to start a for-profit, shared laboratory services company.

Spectrum's hospital owners created the shared laboratory in 1998 to enhance lab services while using consolidation of inpatient testing to squeeze down lab costs. At the same time, the enlarged core laboratory has sufficient specimen volume and cash flow to support an aggressive outreach testing sales program. This generates net profits while further lowering the average cost per test for all specimens.

In tapping Nate Headley to run Spectrum Laboratory Network, its hospital partners selected someone with plenty of business experience in running a hospital-owned laboratory joint venture. Headley was formerly President of **Physicians Clinical Laboratory** (PCL), owned by the **Sutter and Mercy Healthcare Systems** in Sacramento, California.

This hospital lab joint venture was founded in the late 1980s. Headley joined it in 1990 and built it into a publicly-traded laboratory with annual revenues of $111 million at its peak in 1995. Rapid expansion and a precipitous decline in lab reimbursement pushed PCL into bankruptcy reorganization in 1996-7. *(See TDR, November 25, 1996.)*

Spectrum Laboratory Network constructed a 54,000 square foot, state-of-the-art core laboratory in

1998, but its financial performance since that time was disappointing. According to Headley, Spectrum's hospital owners are keenly motivated to make the shared laboratory venture successful.

Less Managed Care

"North Carolina remains a viable market for the sales and marketing of lab services," remarked Nate Headley to THE DARK REPORT, in his first interview since assuming full-time responsibilities as CEO. "Managed care penetration in this area is less than that of California. There is still the potential to leverage additional fee-for-service business from major managed care contracts in this marketplace."

Headley is enthusiastic about the double market opportunity available to Spectrum. "First, our lab supports three hospital systems with a total of 2,200 beds," he noted. "There are a sizeable number of physicians with offices on the campuses of these major hospitals. As their hospital lab, Spectrum is well-positioned to capture lab tests from nearby office-based practices.

Important Foothold

"Second, Spectrum recently signed an important contract with **Partners Health Plan**, a major insurer in North Carolina," continued Headley. "This gives us an important foothold in a large number of physicians' offices. Our sales efforts will concentrate on these physicians."

Headley considers this new opportunity to be deja vu. "There are remarkable parallels between PCL's potential in 1990 and the potential of Spectrum today," he observed. "Lessons learned from the PCL experience at dealing with California's tough managed care market can be put to good use here at Spectrum."

Laboratory executives and pathologists should keep a watchful eye on

Ex-NHL Executives Continue To Pop Up

Nate Headley is the latest ex-National Health Labs executive to assume leadership of a lab company.

First it was Tim Brodnik, who surfaced at American Medical Laboratories in 1997 to become its President and CEO.

During 1999, Bob Whalen became President and CEO of Unilab Corporation after the company had been acquired by Kelso & Company and taken private.

Spectrum Laboratory Network. First, it represents a business model which will become increasingly common: that of a laboratory joint venture owned by multiple hospitals or hospital systems.

Second, unlike many hospital-based laboratories, CEOs of Spectrum's hospital owners are highly supportive of the shared laboratory venture. They are committed to its success and have invested in both equipment and people to create a winning organization. This provides Spectrum with resources and administrative support often lacking in other hospital labs.

Third, Nate Headley has the opportunity to build, for a second time, a shared laboratory joint venture owned by major regional hospitals. If experience does count, then Spectrum seems to have all the resources in place to become a major player in its regional market.

Because multi-hospital systems are now predominant in urban areas, THE DARK REPORT expects to see more shared laboratory joint ventures. **TDR**

Contact Nate Headley at 336-664-6100.

Shared Lab Organizations Evolving Into New Forms

Commercial lab-hospital lab joint ventures giving way to multi-system shared laboratories

CEO SUMMARY: For two decades, the limited number of laboratory joint ventures that appeared were invariably partnerships between commercial labs and hospital labs. Today's hostile healthcare environment makes it tougher for these types of joint ventures to prosper and meet the needs all partners. But the concept of shared lab ventures will not disappear. Now hospital systems are entering the game.

THERE'S ANOTHER SHIFT under way in the healthcare marketplace that is of particular interest to hospital laboratory directors.

This shift involves shared laboratory ventures, and THE DARK REPORT's prediction that a new form of shared laboratory venture is about to supercede the "traditional" JV business model common during the last 15 years.

Since the mid-1980s, the most common model of a shared laboratory organization involved a joint venture partnership between a commercial lab company and a hospital laboratory. That is already changing.

During the next 24 to 36 months, an entirely different shared laboratory business model will become dominant. This will be a shared laboratory services venture. It will be organized, owned, and operated by two or more hospitals or hospital systems within the same metropolitan area.

Commercial laboratories that compete for physician office business will generally not be partners. National reference laboratories will also seldom be equity partners, but may enjoy a special provider status in these multi-system shared lab organizations.

One example of the multi-system shared laboratory joint venture is **Spectrum Laboratory Network**, located in Greensboro, North Carolina. It is owned by **Forsyth Memorial Hospital**, **Moses H. Cone Memorial Hospital**, and **High Point Regional Health System**. Combined, these systems represent 2,200 hospital beds. *(See pages 4-5 in this issue)*.

Examples Of Shared Labs

Another is **Shared Laboratory Services** (SLS), based in Fairfax, Virginia. It is owned by **Chesapeake General Hospital**, **DePaul Medical Center**, **Obici Medical Center**, **Virginia Beach General Hospital**, and **American Medical Laboratory** (AML). AML also is the reference laboratory for the shared lab company.

There are two primary reasons why multi-system lab joint ventures will become the dominant business model.

Hospital Industry Consolidation Shifts Toward Mergers of Healthcare Systems

 # Hospitals Affiliated With an Integrated Healthcare Network

Year	# Hospitals
1995	2,060
1996	2,340
1997	2,681
1998	2,819
1999	3,096
2000	3,078

According to SMG Marketing Group of Chicago, the wave of hospitals joining integrated healthcare networks (IHN) slowed after January 1999. Currently 595 IHNs exist, a number slightly smaller than the 604 that existed in January 1999. These 595 IHNs control 3,078 of the 4,838 acute care, non-government hospitals in the United States. This means 63.6% of the nation's hospitals are now affiliated with IHNs. IHNs will drive the next phase of laboratory regionalization by creating shared laboratory service organizations.

Each is a result of the financial pressures facing all laboratories in today's healthcare marketplace.

First, commercial laboratory companies are finding the current crop of joint venture projects to be financially disappointing. That is one reason there have been few announcements, during the past 12 months, of significant new joint ventures between the largest commercial laboratories and big healthcare systems.

Complicated JV Politics

When the financial under-performance of these JVs is combined with the complicated politics of partnering with hospital administrators, most well-managed commercial labs will choose to devote their resources to other areas of the laboratory marketplace. Thus, the "traditional" joint venture model between commercial labs and hospital (system) labs will become less common.

Second, the financial pressures which forced individual hospitals to consolidate into integrated healthcare networks (IHN) still exist. When the IHN consolidates its laboratory across its hospitals and physician offices, it generally manages to lower costs and improve services.

But the pressure to cut costs further is inexorable. It is this continued financial pressure which now brings the CEOs of healthcare systems together to discuss mergers between their systems and shared laboratory organizations.

If the period of 1993-1999 was a time of hospital consolidation into integrated systems, then the period of 2000-2005 will be when consolidation among hospital systems occurs.

Perceptive lab executives and pathologists are aware that the catalyst to the next big trend in hospital industry consolidation is already upon us. This is the merger of two or more multi-hospital systems. During the next few years, IHN CEOs will seek to solve their operational problems and improve their market share by merging with other healthcare systems.

Hyphenated system names will become common. Expect more "**Memorial-Hermman**" (in Houston) types of health systems to emerge.

But THE DARK REPORT believes that most laboratory regionalization will occur at a level below that of multiple-hospital health system consolidation. In other words, it will be more common to find shared laboratory organizations which were started by

independent healthcare systems in a metropolitan area.

For example, it was announced just last Friday that Milwaukee's **Aurora Healthcare** and Chicago's **Advocate Health Care** will "combine their laboratory operations under a single management team through the development of a joint operating agreement."

Unified Lab Management

This is a perfect example of this new crop of "regionalized, consolidated" laboratory organizations. The systems remain independent, but the laboratory departments are regionalized under unified management. Aurora and Advocate plan to fully integrate these lab functions: LIS, billing, finance, outreach sales and marketing. A centralized management team will direct laboratory operations.

Effectively, the seeds for this new form of laboratory regionalization have already been sown. Some 595 IHNs already control 63.6% of the nation's hospitals, and these are virtually all the hospitals located in urban, developed areas. Thus, hospital lab directors face a new opportunity, or threat, as they choose to view it.

Regional Lab Networks

Regional laboratory networks will continue to play an important role in the process of lab regionalization. But these emerging multi-IHN shared lab service ventures will probably be the bigger agent of change. Unlike the "United Nations" politics of a lab network which delay business implementation, these shared laboratory service ventures will generally be operated like for-profit business units. They will be faster at responding to marketplace needs.

One key to understanding this new market phenomenon is laboratory overcapacity. Most cities in the United States continue to maintain much more clinical lab capacity than is necessary. Moreover, the arrival of automated modular instruments, in tandem with point-of-care testing technology, means there will be an ever-declining need for high-volume core laboratories.

Every year, more and more tests will migrate out of the core lab and move closer to physicians and patients. The laboratory organization will increasingly act as the knowledge resource for diagnostics within the integrated healthcare system.

The need to reduce costs and eliminate unused core lab capacity will drive shared lab organizations. The need to introduce and manage new diagnostic technology will make them increasingly important to healthcare. TDR

Contact Robert Michel at 503-699-0616.

Aurora & Advocate's Lab "Tale of the Tape"

In combining the laboratories of these two large health systems, the executive team will consist of Jay Schamberg, M.D. (Aurora) as General Manager. Cheryl Vance (Advocate) will be Regional VP for Illinois Operations. Marie Cato (Aurora) will be Regional VP of Wisconsin Operations.

Aurora Health Systems:

- **12 acute care hospitals**
- **500 physicians in Aurora Medical Group**
- **Aurora Health Network represents 2,500 physicians**
- **20,000 employees at 230 sites**

Advocate Health Care

- **8 acute care hospitals and 2 children's hospitals**
- **3 affiliated medical groups with 550 physicians**
- **Advocate Health Partners represents 2,265 physicians**
- **21,500 employees at 200 sites**

Labs Essential to Successful Integrated Care

Hospital Labs To Regain Pre-Eminence in Coming Years

CEO SUMMARY: ***During the past five years, powerful forces in the healthcare marketplace positioned hospital-based laboratories to once again become the dominant force in laboratory testing. But this can only occur if today's generation of hospital laboratory directors and clinical pathologists fully understand this opportunity and act to properly prepare their laboratory. It will require a change in strategic focus and management thinking. The successful hospital lab director and clinical pathologist of this new market wave will cease to be caretakers of the testing process and become the diagnostic experts of the integrated healthcare system.***

MOST LAB INDUSTRY EXECUTIVES would agree that the 1990s was brutal on hospital-based laboratories. It was a decade marked by endless budget cutbacks and staff layoffs.

If the decade of the 1990s was bad news for hospital laboratories, then the decade of the 2000s will be just the opposite. There is every indication that the upcoming decade will be a new "golden" age" for hospital laboratories.

The reason is simple. A growing number of senior administrators in multi-hospital systems are recognizing that the clinical laboratory truly has the potential, and the power, to improve clinical outcomes and affect the overall cost of care in a way that is disproportionate to the relatively small dollars spent on laboratory testing.

This is good news for hospital laboratory directors and clinical pathologists. They will enjoy increased importance and respect because clinical laboratories will expand their role beyond the historical function of performing tests and reporting the results to the ordering physician.

This increased respect and influence for hospital labs is a direct consequence from the change in the business goals of integrated healthcare networks (IHN). During the 1990s, IHN CEOs were intensely focused on external business strategies. Now, IHN CEOs must concentrate on internal business strategies. That puts hospital laboratories squarely in the path of the next big national trend in the operation of American hospitals.

Golden Age For Hospital Labs

The impending new golden age of hospital laboratories is a direct consequence of all that occurred during the 1990s. In particular, the major influence now shaping this new golden age is the emergence of multi-hospital health systems as the dominant organization model for urban hospital management. This is having sustained impact on hospital laboratories in a variety of ways.

Invariably, as new hospital systems took form, one of the first clinical services to undergo consolidation was the laboratory. As a result, laboratory organizations in most urban hospitals look much different today than in 1990.

During the last 12 months, the pace of hospital mergers and acquisitions has slowed down dramatically, compared to just a few years ago. The reason is simple. The hospital industry has consolidated itself into integrated healthcare networks.

Of the nation's 4,838 non-government acute care hospitals, 3,078 are now part of an IHN. With 63.6% of the nation's hospitals part of an IHN, there is little opportunity remaining for further hospital acquisitions. *(See sidebar on page 7 with IHN statistics.)*

Effectively, the dominant hospital industry trend of IHN formation ended during 1999. For hospital laboratories, this is a significant development, because 2000 marks a widespread shift in the business goals of IHN CEOs.

Prior to 1999, administration of the typical IHN was focused on an external business strategy. The IHN was doing mergers and acquisitions with other hospitals in the region. These acquisitions were done to establish a competitive presence in the local marketplace.

External Business Strategy

The reasons for hospital acquisitions were several: to build market share; to prevent competing IHNs from establishing a foothold, and to gain the buildings and service resources necessary to win managed care contracts in the metropolitan area.

Once an IHN acquires the basic group of hospitals which anchor its system, the external business strategy ceases to be the primary focus of its CEO. Beginning in 2000, most IHN administrators are shifting to an internal business strategy: achieving operational and clinical integration.

As most hospital lab administrators are painfully aware, the first implementation of

the internal business strategy has been to consolidate clinical services. Usually laboratories were the first clinical services to implement consolidations within the IHN. The reason is obvious. It's easier to move lab specimens between hospitals than shift patients.

Intermountain Health Picked As Top IHN

In the latest annual ranking of the nation's top 100 integrated healthcare networks (IHN) by SMG Marketing Group of Chicago, it is Intermountain Health Care (IHC) which tops the list. IHC replaces last year's top performer, which was Advocate Health System of Oakbrook, Illinois.

Located in Salt Lake City, Utah, ICH includes 20 hospitals, clinics, 2,500 affiliated physicians, 400 contractual physicians, and its own health insurance plans.

SMG uses 31 key IHN data elements to rank the nation's most progressive IHNs. These include hospital utilization (for IHC, an occupancy rate of 48.9% with a severity adjusted average length of stay of 4.66 days), financials, service & access, physician participation, outpatient utilization, and integration of operations, clinical services, and technology.

THE DARK REPORT observes that most of the nation's IHNs have already accomplished some degree of laboratory consolidation. In fact, since the mid-1990s, many IHNs consolidated laboratory services in several incremental steps. Each consolidation project squeezed more cost from the laboratory division. The objective was to harvest obvious cost savings by developing a high-volume core lab, standardizing instruments and reagents, creating a unified lab management structure across all hospital labs in the IHN, and achieving a common LIS platform for capturing, storing, and reporting laboratory test results.

Taken collectively across the nation, these hospital lab consolidation efforts brought about a tremendous concentration of management responsibility. It has also thinned the ranks of hospital lab directors. As IHNs acquired new hospitals, they moved to consolidate laboratory testing. This involved eliminating individual hospital lab directors and creating a unified lab administration.

Fewer Hospital Lab Directors

One good example of how this process thinned the ranks of hospital lab directors is the **Tenet Healthcare** lab project in Southern California. During 1998 and 1999, Tenet took the laboratory functions of 30 hospitals in Los Angeles and Orange Counties and created a regionalized lab structure.

Using **SmithKline Beecham Clinical Laboratories** (SBCL) as a consulting and implementation resource, Tenet created two core labs and 10 (rapid response) hospital lab clusters, based on geographical proximity of the hospitals. When completed, Tenet's 30 lab directors had been pared down to two core lab administrators and 10 cluster lab managers. In the space of 90 days, 30 hospital lab directors were reduced to 12 lab administrators. *(See TDR, January 19, 1998.)*

Urban Hospital Labs

This example typifies the consolidation process that most urban hospital laboratories have undergone during the past five years. It was a direct consequence of the widespread formation of new integrated healthcare networks. That market cycle ran its course in 1999.

The end of this epic period of IHN creation sets the stage for the hospital labs' next golden age. Each IHN has organizational infrastructure that needs enhanced

services, management expertise, and clinical support from its lab division.

Even as the moment arrives when IHNs will ask more from their laboratories, new diagnostic instruments and technologies are entering the marketplace. Match these together, and it is one of those rare moments in life when various market forces come together to make hospital laboratories the right answer to the most compelling challenge facing the nation's 595 IHNs.

Clinical Resources

The question is simple. With all the clinical resources now under common management, how does the typical IHN actually best achieve clinical and operational integration?

Few examples exist to guide both IHN CEOs and hospital laboratory administrators. **Kaiser Permanente** is widely-hailed as a model of effective integration. **Group Health Cooperative** in Seattle is another. Both organizations sprouted decades ago, and have developed full integration of clinical and operational resources. But their business model is not easily applied to the IHNs which are operated by such owners as Tenet or a Catholic charitable organization.

Great Leverage

Hospital laboratory directors and pathologists understand the laboratory has great leverage to improve the quality of care while reducing costs. What will surprise them in coming years is that their IHN CEO will come to recognize the same fact.

There is an oft-quoted statistic among laboratorians. It lacks definitive attribution, but has the ring of truth. This statistic says that 60% of all decisions to admit or discharge a patient from the hospital rely, to some degree, on laboratory test results. In contrast, the laboratory typically represents only about 5% to 9% of a hospital's annual operating budget.

THE DARK REPORT sees evidence that a growing number of senior IHN administrators are recognizing that the laboratory may be the right tool to expedite clinical and operational integration. Their need for better clinical outcomes at ever-decreasing costs will force them to give more recognition to the value of laboratory testing. It means closer cooperation with their laboratory management team and pathologists.

Compelling proof of this fact comes from **Premier, Inc.**, the national group purchasing organization (GPO) that serves 1,700 member hospitals. In May 1998, it announced a major strategic services alliance with **Quest Diagnostics Incorporated**. The goal was for the two companies to assist hospitals and healthcare systems gain the maximum potential benefit from their laboratory organization.

Failed To Meet Expectations

In the past 23 months, the strategic services alliance has failed to meet expectations. That performance has surprised few industry observers. After all, hospital administrators like to keep control over all their operations, and that includes the laboratory. The Premier-Quest alliance had some difficult business challenges to succeed in its goals.

But THE DARK REPORT has always believed that there was another reason why the news of the Premier-Quest strategic laboratory services alliance was important. Premier's decision to participate in the upgrading of hospital laboratory function and performance is a validation of the hospital laboratory's vital role within the integrated healthcare system.

For that reason, we extensively interviewed Premier executives Bill Nydam, then Executive Vice President at Premier, and John Biggers, then Premier's Vice President of Corporate Business Development. The two-part interview was revealing as to the poten-

tial of the clinical laboratory to be a fulcrum of change within IHNs. *(See TDR, June 15 and July 6, 1998.)*

Nydam characterized Premier's laboratory alliance as a "breakthrough" initiative that "should fundamentally change the way healthcare services are delivered and generate benefits which had previously been unattainable."

Leverage Improvement

Biggers stated that "A number of CEOs among our hospital owners pointed out to us that clinical laboratory data might be a fulcrum to leverage improvement in both clinical and operational integration within their healthcare system. A lot of our hospitals recognized that this was a good area to rally around as they attempt to build up their networks."

These statements, made after 18 months of intensive meetings with Premier's various hospitals and IHNs, demonstrate that, even in 1998, a sizeable number of IHN CEOs appreciated the potential of clinical laboratories to help the integration of health care.

The truth of these statements is further validated by the appearance of multi-hospital laboratory shared services ventures during the past 24 months. In this issue, we've mentioned **Spectrum Laboratory Network** in Greensboro, North Carolina and the just-announced combination of the lab divisions of **Aurora Healthcare** (Milwaukee) and **Advocate Health Care** (Chicago). *(See pages 6-8)*.

Measure And Quantify

THE DARK REPORT's prediction of a new golden age for hospital laboratories will not happen overnight. There will be progressive IHNs which act ahead of their peers. It will take them a couple of years to measure and quantify the successes generated by these projects.

But once that occurs, the compelling economics of a proactive hospital laboratory organization will make it imperative that all viable IHNs give a greater role to diagnostic testing within their systems.

It is important to recognize that these developments will take place even as radical improvements are made to laboratory technology. This includes automated, modular workstations which steadily shrink in size. There will be increased point-of-care testing technology. Molecular and genetics-based assays will provide new opportunities to detect disease earlier, with greater accuracy, and at less expense.

Of course, overhanging all these changes is the Internet and healthcare E-commerce. The information revolution will work its magic on the clinical laboratory. It will tie together all these emerging new technologies.

Enhanced Laboratory Role

For hospital lab administrators and pathologists, the enhanced role of the laboratory within the typical IHN means doing more with fewer people. It will require flexibility to adapt new technologies earlier in the implementation curve.

At the same time, diagnostic testing will move outside the core lab and closer to the patient. The **PennState-Geisinger Health System** is undergoing precisely this type of evolution. To support it, laboratory administration is moving outside the core lab and interacting with clinicians and other providers in the locations where specimens are collected and the tests performed.

This new golden age of hospital laboratories is already upon us. Healthcare market dynamics of the 1990s, in creating an IHN-dominated hospital industry, have prepared the stage.

Now it is up to resourceful hospital lab administrators to demonstrate how the potential of lab testing to lower costs and enhance outcomes can be converted into reality. **TDR**

Contact Robert Michel at 503-699-0616.

Aetna Settles Texas Suit, To Reform Care Policies

Nation's largest health insurer agrees to patient and provider-friendly changes

CEO SUMMARY: Texas demonstrates that, where providers have political clout, some of the more onerous aspects of managed care can be changed. The Texas Attorney General sued Aetna and five other HMOs in 1998 about the way physicians were given incentives to stay within budget numbers for the cost of care. Aetna decided to settle out of court. It has agreed to some surprising changes.

TEXAS CONTINUES TO BE the nation's leader in using the powers of government to support the cause of physicians, healthcare providers, and patients against managed care companies.

On April 11, it was announced that **Aetna Inc.** and the Texas Attorney General had signed an agreement to settle the existing lawsuit against the company. Aetna agreed to revise and reform a number of business practices that affect both providers and patients.

Will Stop Fining Doctors

Aetna agreed, among other things, to stop fining doctors whose patient care levels exceed allowable limits and, conversely, rewarding those whose care levels fall below HMO spending guidelines. Another key feature was a change from capitation to fee-for-service for physicians providing care to less than 100 Aetna HMO patients.

Texas Attorney General John Cornyn pursued the action brought by predecessor Dan Morales in 1998 against Aetna and five other HMOs. Aetna has a large footprint in Texas: 960,000 HMO members, with 2.4 million in all its health care lines.

Another big issue in the settlement is that, instead of being required to provide care for all of Aetna's health plan products, physicians can choose which plans for which they will provide services. "Elimination of the all-products clause is a big deal," observed John Rex, an analyst at **Bear Stearns**. "It's the biggest issue that providers had. Frankly, Aetna probably needed to head that way anyway."

For laboratory executives and pathologists watching the evolution of the managed healthcare marketplace, this settlement agreement is a significant event. It shows that the large HMOs want to avoid going to court to defend themselves against charges of rationing or withholding medical care.

In other words, the mounting legal challenges to how managed care companies manage their business affairs is having a cumulative impact. During the past 18 months, a growing number

of lawsuits, including class action lawsuits, have been filed against a number of the managed care giants.

In the case of Aetna, during 1999, a civil class action RICO (fraud, racketeering) lawsuit, *Maio vs Aetna, Inc.* was filed in federal court by consumer-plaintiffs who alleged they had been lured by false promises of high-quality care while at the same time Aetna pressured doctors to cut costs and provide minimal care. The Maio action was dismissed in October 1999. The judge ruled the plaintiffs' pleading raised insufficient issues and they did not have standing to sue.

Legal Liability Of HMOs

The potential legal exposure that HMOs face should not be underestimated. As consumers and physicians experienced the arbitrary ways in which medical care was authorized and provided during the last ten years, an increasing number have turned to legal and legislative remedies.

The Texas legislature and executive branch have proved friendly to doctors and healthcare providers. During 1999, the state passed a bill allowing physicians to bargain collectively.

Contrast this willingness in Texas to side with physicians to that of California, where physicians seem to be political eunuchs when it comes to getting the state legislature to pass doctor-friendly bills to rein in the worst abuses of the state's managed care insurers.

Two-Fold Significance

THE DARK REPORT believes the significance of the Aetna settlement in Texas is two-fold. First, it shows how a state government that is responsive to the needs of healthcare providers can help balance the power relationship that exists between payers and providers, including laboratories.

Second, the threat of direct lawsuits now creates a new area of operational concern for HMOs. To avoid lawsuits, these companies will move decisively to make it appear they do not make, or influence, clinical decisions which involve providing or withholding medical care.

Both developments should be favorable to all healthcare providers, including clinical laboratories and pathology group practices. TDR

Aetna Agrees to Reform Some Practices In Texas

Here are the important elements of the settlement between Aetna and the Texas Attorney General, announced on April 11.

KEY POINTS FOR PHYSICIANS

- Each physician can choose to provide for any or all of Aetna/USH's product lines.
- 90-day notice of significant changes in policies regarding physician participation in Aetna/USH networks.
- Physicians with less than 100 HMO patients will now be paid on a fee-for-service basis, not capitation.

KEY POINTS FOR PATIENTS:

- Expanded external review, including appeals of coverage for experimental/investigational, emergency, prescription drugs, and standing referrals to specialists.
- Will create the Office of the Ombudsman for Texas HMO members. Acts as advocate and gives assistance on appeals or complaints.
- Medical necessity decisions made by Texas MDs will be based on state-of-the-art, publicly-disclosed standards.
- Physicians to apply same standard of care to all patients, regardless of benefit plan or type of coverage.
- Conduct studies and programs to detect and prevent underutilization of health care services, especially for women, minorities and the chronically ill.

Humana Denies Payment For Pathology CPT Codes

Certain surgical path CPT codes rejected across New England, Midwest, and the South

CEO SUMMARY: It's not just the Medicare program that wants to eat away at the reimbursement for laboratory tests. Private payers continue to seek ways to cut back reimbursement to laboratory providers. The latest attack is on two surgical pathology codes—88300 and 88302. In at least three states, Humana Healthcare Corporation has denied claims submitted by pathologists for these procedures.

HERE'S FIRST NEWS OF ANOTHER attempt by a major health insurer to arbitrarily reverse payment for accepted clinical practices that are integral to the relationship between pathologist, referring surgeon, and patient.

Humana Health Plans, headquartered in Louisville, Kentucky, has begun to deny claims for CPT codes 88300 and 88302 in at least three states, Michigan, Wisconsin, and South Carolina.

Pathology Service Associates, LLC (PSA), the national organization of state pathology networks, reports that PSA member pathology practices in these states were denied claims submitted to Humana for these CPT codes.

Dennis Padget, President of **Padget Associates** in Simpsonville, Kentucky, saw the same activity as early as January in the Northeast and New England. "Humana's denials cropped up in a number of states in this region," he noted. "The **Massachusetts Pathology Society** is taking an active interest in resolving this, but I think it will require action at the national level."

"The two CPT codes in question basically cover the pathologist's examination of tissues involved in minor surgeries," stated Louis D. Wright, Jr., M.D., Chairman of PSA. "This is accepted clinical practice. These examinations verify, for both the surgeon and the patient, that surgeons removed the correct tissues. The pathologist also makes a determination as to whether the tissues did or did not contain disease. Moreover, clinical requirements compel surgeons to refer these tissues to pathologists, and compel pathologists to examine them."

Humana's Explanation

In a letter to a PSA pathologist dated March 29, 2000, The Humana plan in South Carolina denied payment for an 88302 claim. It gave as a reason "The level II gross and microscopic examination is a standard procedure that most hospitals require as a quality assurance measure. Since it is a quality assurance measure versus the treatment of an illness or injury, we have determined that the pathologist should be reimbursed by

Humana Begins To Deny Claims For 88300 & 88302

During the last 90 days, Humana Healthcare began denying claims for CPT codes 88300 and 88302. Humana sent the letter at left to a South Carolina pathologist in response to his claim for pathology services rendered under CPT code 88302.

Humana denies payment, explaining that it considers 88302 to be “a standard procedure that most hospitals require as a quality assurance measure. Since it is a quality assurance measure versus the treatment of an illness or injury, we have determined that the pathologist should be reimbursed by the hospital, and not the insurance company.”

Humana Inc.
PO Box 5620
Madison, WI 53705-0620
800 558 4444 Toll-Free

HUMANA

March 29, 2000

[redacted]
P 0. Box 100559
Florence. SC 29501-0559

Re: Employee [redacted]
Patient [redacted]
ID Number [redacted]
Group Number [redacted]

Dear Mr. [redacted]

This letter is in response to your request for a review of the benefit determination for services provided to [redacted] on November 15, 1999. Humana/Employers Health has carefully reviewed all of the information provided and we are reaffirming our denial. The following is a summary of the information considered in this review.

Information Reviewed:
- 1999 CPT-4 Manual
- Claims submitted for services rendered on November 15, 1999 by Dr. [redacted]
- Explanation of Benefits (EOB) for date of service November 15, 1999
- Pathology report dated November 15, 1999

Reason for Decision:
PT (Current Procedural Terminology) code 68302 is billed when a Level II - Surgical pathology, gross and microscopic examination is performed. A Level II gross and microscopic pathological examination consists of the physician sending the tissue or object removed to a pathologist. The pathologist identifies the specimen to verify the physician removed the correct object or tissue. The types of tissue which are considered under this code are typically removed during surgeries where disease is not present, such as tubal ligations, circumcisions, vasectomies, etc.

The Level II gross and microscopic examination is a standard procedure that most hospitals require as a quality assurance measure. Since it is a quality assurance measure versus the treatment of an illness or injury, we have determined that the pathologist should be reimbursed by the hospital, and not the insurance company.

Therefore, we are reaffirming our denial of CPT code 88302.

Humana/Employers Health invites you to submit any additional materials, comments or your written request for further review within 60 days of receipt of this letter.

[redacted]
March 29, 2000
Page 2

We appreciate the time you have taken to express your concerns and hope this letter satisfactorily explains our position If you have any additional questions please contact our office.

Sincerely,

HUMANA/EMPLOYERS HEALTH

Pat Hertzog

Pat Hertzog
Customer Service Claims Specialist
Claims Division

the hospital, and not the insurance company.”

Dr. Wright says that a study of PSA member practices indicates that 88300 generates between 0.01% and 1.2% of annual billings. CPT 88302 generates between 0.05% and 2.8% of annual billings. Combined, these procedures can generate as much as 4% of annual billed revenues for a pathology practice.

PSA notified the **College of American Pathology** (CAP) about this situation. CAP reports similar denials by Humana in Georgia, Wisconsin, Massachusetts, and Nevada.

Humana’s actions should raise a red flag for all lab executives and pathologists. Its attempts to deny payments for a clinical procedure which has unquestioned clinical value, and which is mandated by medical standards and requirements, demonstrates that both clinical laboratories and pathology practices should be vigilent to similar arbitrary denials of even minor CPT codes.

THE DARK REPORT is aware of anecdotal episodes of arbitrary claims denials experienced by individual labs in different parts of the country for different CPT codes. This latest episode, unearthed by Dennis Padget and PSA, demonstrates that, like liberty, eternal vigilence is a requirement to insure full payment of legitimate claims. TDR

Contact Louis D. Wright, Jr., M.D. at 843-679-4779 and Dennis Padgett at 502-722-8873.

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

Here's an update on the number of integrated healthcare networks in the United States. **SMG Marketing Group, Inc.** of Chicago reports that IHNs seem here to stay. Between January 1999 and January 2000, the number of IHNs decreased from 604 to 595. That number is misleading, however. SMG says that "evidence of the staying power of IHNs is the fact that, although 27 IHNs closed or merged since January 1999, 18 networks opened during that same period." It also notes that mergers may have reduced the number of IHNs, but the hospitals involved still remain in an IHN.

MORE ON: HOSPITAL IHNS

Since January 1999, the total number of hospitals participating in IHNs dropped by only 38, from 3,096 to 3,058. SMG claims at least 50% of these were related to the developments at **Allegheny Health Education and Research Foundation** and **Columbia/HCA Healthcare Corporation**.

ABATON.COM WINS NYC'S WEILL CORNELL LAB OUTREACH PACT

Expect the race to bring clinical laboratories into the Internet age to be similar to the nuclear arms race between the former Soviet Union and the United States. Vendors of all sizes and stripes are furiously competing to sign up their first laboratory customers. At the **Weill Cornell Medical Center of New York-Presbyterian Hospital**, an RFP for Web-based lab ordering/results reporting for the lab's physician outreach clients was won by **Abaton.com**. Apparently it was a hard-fought competition between **Abaton.com**, **Advanced Health Technologies**, **Healtheon/ WebMD**, and **Medical Logic**.

ADD TO: ABATON.COM

All four companies considered the Weill Cornell account to be a prize. Harlan Bass, Administrative Director of Laboratories at the hospital, was eagerly pursued by the prospective vendors. Apparently one goal of the lab outreach program was to implement this new Web-based feature as soon as possible, since, in the competitive Manhattan marketplace, physician office clients have high expectations for laboratory services.

INFO WANTED

Insider news and tips about labs are always welcome. Call or email in confidence: 503-699-0616 or labletter@aol.com.

INSURERS STRIKE BACK

Healtheon/WebMD finally woke the sleeping giant. THE DARK REPORT has predicted that the nation's health insurers would not cede claims processing and administration to Healtheon/ WebMD without a fight. On March 30, **Aetna**, **Cigna**, **WellPoint**, **Oxford**, **Foundation Health**, and **PacifiCare** announced that they would enter the healthcare E-commerce arena. Together, they are forming a company to be called **MedUnite**. This new company will offer electronic claims processing. Med Unite can potentially serve 30 million customers. This is about 15% of the 200 million Americans with health coverage.

That's all the insider intelligence for this report. Look for the next briefing on Monday, May 15, 2000.

PREVIEW #5

EXECUTIVE WAR COLLEGE

May 16-17, 2000 • Fairmont Hotel • New Orleans

Topic: Making Automated Pap Smear Technology Work in the Clinical Laboratory

Each generation of automated Pap smear technology brings additional refinements to the performance and cost effectiveness of these procedures. Here s an exclusive look at a laboratory which is using a fully-automated liquid preparation module hooked directly to an automated Pap smear screener in day-to-day clinical operations.

Full program details available by calling 800.560.6363
or visit darkreport.com

UPCOMING...

- ***The Dark Report's Annual Look at Year's Best-Selling Laboratory Information Systems.***
- ***Modular Automation Works Wonders at Consolidated Lab—and Pays for Itself!***
- ***Latest News on Regional Laboratory Network Successes.***
- ***Pathology Group Practice Consolidation Continues to Change Competitive Dynamics.***