Volume IV, Number 18 Monday, December 29, 1997

From the Desk of R. Lewis Dark...

THE DARK REPORT

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

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Commentary & Opinion by...

R. Lewis Dark

Founder & Publisher

No Slice of the Pie for Pathology and Laboratory

Managed care appears to be ready to minimize pathology in the same fashion as it minimized the clinical laboratory. Within the laboratory industry, it is widely recognized that most managed care plans reimburse laboratory services at levels which are inadequate to cover the full cost of testing.

Now it may be pathology's turn. In the market evolution of healthcare, Medicare HMOs may be the next major trend to reprice and restructure a considerable segment of the healthcare marketplace. In just four years, from 1993 to 1997, Medicare HMOs have increased their share of the Medicare market from 5% to 10%. With 40 million seniors enrolled in Medicare, and 80,000 per month switching into Medicare HMOs, I predict that the Medicare market segment will undergo profound changes during the next two or three years.

This does not bode well for either clinical laboratories or pathologists. Medicare business comprises a large portion of the specimens for both laboratories and pathologists. In a Medicare managed care format, this business will be drastically repriced...downward!

Pathologists, in particular, should be concerned about this potential series of events. A careful reading of our presentation on Medicare HMOs in this issue *(pages 9-15)* will demonstrate why an increasing amount of pathology work will originate outside the hospital. Because most pathologists are hospital-based, this is a trend which will displace traditional hospital-based pathology groups and favor those pathology groups which serve both hospitals and physician offices.

Further, clinical laboratories and pathologists should realize how these Medicare HMOs reward hospitals and contracted physicians at the back-end, through risk-sharing arrangements. These two classes of providers thus have access to extra dollars above the prospective monthly reimbursement. Ancillary providers, including laboratories, pathologists, radiologists, etc., are generally denied participation in the risk-sharing pool. But these are dollars which "sweeten the capitation pot" for hospitals and the contracted physicians. In the true sense, it creates an unequal economic environment.

Since there is no slice of the risk-sharing pie for laboratories and pathologists, is there any way to change this situation? I believe the answer is yes. I believe the answer lies in a combination of increased participation at the contract negotiating table, offering clinical services which are recognized as essential and "value-added," and creating regional provider organizations which carry negotiating clout because of their size and reach. For pathologists currently entrenched within a hospital, this kind of collaboration represents a huge paradigm shift. TDR

1997's Top Ten Lab Stories Predict New Directions

Review of top lab industry stories for 1997 demonstrates how the marketplace is shifting

CEO SUMMARY: Events during 1997 reveal that the laboratory industry continues to undergo fundamental change. Yet even amidst the industry's downsizing, selected laboratory organizations continue to flourish. Here is THE DARK REPORT's annual look at top stories for the year. A careful analysis of their impact leads to some interesting conclusions.

WHEN FEDERAL REGULATORS introduced a rigorous laboratory compliance program last February, few laboratory executives understood the major ramifications of this development.

After all, it was the $325 million settlement between **SmithKline Beecham PLC** and the federal government which attracted headlines. It was a huge recovery by the government, and allegations against SmithKline included a variety of business practices, some common throughout the laboratory industry.

But the real news was not SmithKline's settlement and fine, it was the unexpected introduction of a laboratory compliance program. Government prosecutors, after investigating virtually every large commercial laboratory and a host of hospital laboratories, decided that violations of Medicare fraud and abuse statutes were both widespread and ongoing. To stop these practices, regulators want each laboratory organization in the United States to institute a rigorous compliance program. For this reason, laboratory compliance is recognized as the top story of 1997.

In announcing the requirement that laboratories would need to develop compliance programs, government enforcers put serious teeth into the consequences of failure. As laboratory executives learned about the requirements for a laboratory compliance program, they made a disturbing discovery.

Both the **Department of Justice** and the **Office Of Inspector General** (OIG) declared that violations of Medicare coding and reimbursement guidelines would henceforth be considered serious enough to warrant criminal charges and jail time for any laboratory

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THE DARK REPORT Intelligence Briefings for Laboratory CEOs, COOs, and CFOs are sent 17 times per year by The Dark Group, Inc., 1731 Woodland Terrace Center, Lake Oswego, Oregon 97034, Voice 1.800.560.6363, Fax 503.699.0969.

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SUBSCRIPTION TO THE DARK REPORT INTELLIGENCE SERVICE, which includes THE DARK REPORT plus timely briefings and private teleconferences, is $10.80 per week in the US, $11.40 per week in Canada, $12.45 per week elsewhere (billed semi-annually).

manager deemed responsible for a laboratory's failure to follow the compliance program.

This laboratory compliance program is 1997's biggest story for two reasons. First, every laboratory in the United States must respond. Second, a personal threat of civil and criminal charges now confronts every laboratory manager with oversight responsibility for Medicare billing and reimbursement activities within the laboratory

These stories are evidence of the ongoing market forces now reshaping both healthcare and the clinical laboratory industry.

Excluding the bombshell news of universal laboratory compliance programs, 1997 might otherwise be viewed as a "quiet" year. None of the remaining stories in our top ten list has either the drama or serious impact of the heightened government regulation of laboratory activities.

However, the other top stories on our list are not inconsequential. To the contrary, each of our top stories will influence and change traditional laboratory practices. These stories are evidence of the ongoing market forces now reshaping healthcare and the clinical laboratory industry.

Ranking By Importance

Ranking the relative importance of our top ten news stories for 1997 is difficult. Does the arrival of pathology practice management companies rank higher than the financial struggles of national HMOs? Does consolidation of the diagnostics industry have more importance than introduction of automated cytology technology?

We believe that individual laboratories would prioritize our list differently, based on how they see the impact of these stories on their operations. Accordingly, we present the top stories of 1997 "as-is," with no attempt to prioritize their importance.

It is worthwhile to note that these top stories cover a range of management issues in the laboratory industry. For example, the diagnostics industry is about to undergo a wave of consolidation. Diagnostics companies supply laboratories with instruments and reagents. Turmoil caused by mergers and acquisitions will directly impact how these companies service their laboratory customers.

Continued growth and profits of specialty and boutique laboratories indicate that some clinicians and payers still value diagnostic testing. But even as specialized reference and esoteric laboratories prosper, those laboratories performing high volumes of routine testing continue to see significant declines in their reimbursement.

HMO Financial Woes

Financial woes of national HMOs presage continued financial pressure for clinical laboratories. If the HMOs cannot make money themselves, how can they find extra funds to increase laboratory reimbursement? This is one developing story which THE DARK REPORT predicts will have major impact on the financial health of large laboratories during the immediate future.

Pathology is about to undergo a radical similar market transformation. The fact that venture capitalists are willing to fund pathology-based physician practice management companies is evidence of their belief that new business models can outcompete existing pathology practices.

Add up the impact of these "top ten" stories for 1997 and one conclusion jumps out: 1998 will be a year of continual and dramatic change, both for clinical laboratories and for pathology. TDR

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1 Laboratory Compliance Program Follows SmithKline Settlement

AFTER SmithKline Beecham agreed to pay $325 million to settle allegations of Medicare fraud and abuse last February, news media publicized the agreement as the largest healthcare fraud case ever to be settled.

For the laboratory industry, the real news was not the size of SmithKline's settlement, but the simultaneous announcement by federal authorities that clinical laboratories should immediately implement a compliance program.

Although the implication was that such compliance programs would be a voluntary act on the part of laboratories, federal prosecutors made it clear that any future allegations of Medicare fraud and abuse would include harsh penalties. Not only would there be civil fines, but prosecutors declared their intention to pursue criminal charges against both corporations and their executives.

If any laboratory executive doubted the seriousness of this threat, they had only to see what federal prosecutors did to executives at **Columbia/HCA Healthcare**. After widely-publicized raids in April and June, three of Columbia's executives in the Florida division were indicted in July. *(See TDR, August 4, 1997.)*

Laboratory compliance programs only mark a first step in what will become a major intrusion by the government into every aspect of clinical laboratory operations. Genuine concerns about healthcare fraud will prove to be the Trojan Horse used by the government to interfere in lab operations.

2 Niche and Boutique Laboratory Providers Enjoy Growth, Profits

COMPARED TO the financial performance of commercial labs, boutique and niche laboratories demonstrated surprisingly strong growth in revenue and operating profits during 1997.

This illustrates that it is still possible for laboratories to make money in a managed care world. But the profits will not got to laboratories offering routine tests and common reference assays.

Instead, the performance of diagnostic laboratory providers such as **UroCor, Inc.**; **DIANON Systems, Inc.; ImPath, Inc.**; **Rheumatology Diagnostics Laboratory, Inc.; Endocrine Sciences** and others derives from their ability to provide value-added services to a specialized segment of the healthcare community.

Not only do these specialty laboratories offer diagnostic tests which have high value to clinicians, but the need to tailor testing and related services to the clinicians ordering these assays naturally creates tighter bonds between these laboratories and their physician clients.

In 1998 and beyond, routine laboratory testing will continue to be consolidated into regional laboratory centers. Reimbursement for such testing will continue to decline.

Meanwhile, specialty testing will increase. Because of the high value placed on such tests by clinicians, specialty test providers will generally earn higher profit margins than their general reference laboratory competitors.

3 What Didn't Happen in 1997: A Cascade of National Lab Contracts

HERE IS A STORY WHICH IS SIGNIFICANT because it *didn't* happen! As national HMOs continued to grow and expand, many observers expected these companies to negotiate exclusive national contracts for laboratory services.

But only **United Healthcare** announced a national laboratory contract, involving SmithKline Beecham Clinical Laboratories and **Laboratory Corp. of America**. No other national HMOs moved to follow the example of **Cigna Healthcare**, which did a sole-source, exclusive national laboratory contract with SmithKline in 1995.

Had most other national HMOs and insurance corporations followed Cigna's example of an exclusive, sole source contract for national services, both small regional laboratories and hospital lab outreach programs would have been severely impacted.

Maybe the real story lies in the difficulties experienced by both Cigna and SmithKline in making the 1995 contract work. Although both companies publicly state that the relationship has been satisfactory, regional laboratory providers in various parts of the country tell a different story.

There is another reason why national laboratory contracts failed to appear at other large HMOs. The HMOs themselves now struggle with problems resulting from their own expansion, so management is focused towards other areas. But a current reading of the market seems to indicate that national contracts will be less of a threat than was considered true in 1995.

4 Venture Capital Markets Support Formation of Pathology PPMs

AFTER 1997, THE PROFESSION of pathology will never be the same. Pathology-based physician practice management (PPM) companies arrived on the scene with much ballyhoo and fanfare.

AmeriPath, Inc. was the first pathology PPM to appear. Funded by venture capitalists several years ago, it successfully went public in October. Its initial public offering raised $89.6 million. In December, **Physician Solutions** announced an agreement to access a capital line of $18 million, also funded by venture capitalists.

Like it or not, it is the venture capitalists which provide the capital for these companies to pursue their vision of what the business of pathology should be. Money talks, and AmeriPath has already spent $200 million buying pathology practices.

Irrevocable market forces are now unleashed. Pathologists will be confronted with a serious decision. Should they sell their practice to a PPM? If not, what should they do to compete against pathology PPMs?

The more sophisticated business minds among pathologists already appreciate that the real dilemma is not whether to buy or sell their practice. The real dilemma involves the correct strategy to fend off these PPMs when they send their sales reps to hospitals to capture anatomic pathology contracts. Pathology PPMs are a direct threat to hospital-based pathologists.

5 National HMOs Find Themselves Facing Sustained Financial Woes

THERE MAY BE THE MOST OVERLOOKED story of the year. HMOs are losing money, with no clear turnaround date in sight. Indications are that the HMO industry suffers from serious operational problems which may take some time to overcome.

Financial health of the national HMOs is a prime concern to all healthcare providers, not just laboratories. If HMOs cannot make money, they will attempt to lower reimbursement even further. This increases financial pressure on healthcare providers, particularly clinical laboratories.

Prudential's fiscal woes have been public for several years. But Wall Street was surprised by a string of announcements during the last half of 1997, as **Oxford**, **Aetna/US Healthcare**, **PacifiCare** and others revealed their struggles to maintain operating profits and earnings.

From a practical perspective, adequate reimbursement can only flow from financially healthy HMOs. THE DARK REPORT believes that HMOs and managed care plans as we know them today will not be the final or best solution to healthcare. But during the short-term, ailing HMOs will only complicate the financial challenges confronting clinical laboratories.

This is an important story. All laboratory administrators and executives should carefully track the financial performance of the largest HMOs. Should they continue to do poorly, laboratories and other providers will bear the burden.

6 Automated Cytology Systems Gaining Marketplace Acceptance

IN 1996, AUTOMATED CYTOLOGY SYSTEMS were a novelty. During 1997, these same systems became a regular feature in the marketplace.

Currently only a limited number of laboratories actually use these products. But that will rapidly change. Ongoing sales and marketing campaigns by the three major vendors of automated cytology systems are building awareness of their products among laboratory executives.

More importantly, collective efforts by these three companies to obtain appropriate CPT codes brought about exactly that result. Starting in 1998, there are CPT codes for the automated cytology procedures. In response, a few managed care plans are announcing their willingness to reimburse automated cytology procedures.

Although many laboratories naysayed this technology, THE DARK REPORT consistently predicted that it would eventually carve itself a place in the market. That seems to be occurring, although at a slow pace.

The added cost of this technology is an issue. But clinical use of this technology generates an ever-growing body of data as to the clinical and economic effectiveness of automated cytology systems. The actual performance of each technology in the marketplace will determine its fate. If these systems provide clinical value, data will demonstrate that. If they cost too much, economic data will demonstrate that too.

7 Paradigm Shift: National Labs No Longer Bullies In the Market

DATING FROM THE MID-1980s, large commercial laboratories dominated the marketplace. In 1997, that ceased to be true.

For many years, hospital labs and the independent commercial laboratories resented the way the national labs used loss-leader pricing to scoop clients and market share away from local competitors. Small competitors were unable or unwilling to match sales strategies that ranged from test unbundling to client-bill discounting on high-volume, routine testing.

Because of these, and other practices, national laboratories dominated the price and service infrastructure of each local market. Smaller competitors were at a disadvantage because they lacked sufficient capital and market clout.

That is changing. After several years of huge losses, the three blood brothers were forced to acknowledge their sins. Old business practices and attitudes have been tossed aside. The national labs are quietly evaluating individual accounts on the basis of profitability. They are eliminating excess laboratory capacity. Contracts are renewed at higher prices wherever possible.

Yet none of that will help. THE DARK REPORT was the first publication to chronicle the success of local laboratory competitors against the nationals. In market after market, a well-managed local lab, armed with a professional sales program and good service, is building market share at the expense of their national competitors. The pendulum now swings away from national labs.

8 Lab Administrators Finally See Need to Change Lab Operations

AFTER MANY YEARS OF DENIAL, a growing number of hospital laboratory administrators now acknowledge the need for change. As a result, the pace of hospital laboratory restructuring and reengineering will increase.

Whereas in previous years, most hospital laboratory administrators would offer all sorts of reasons why there was no need for them to restructure their laboratory, that has ended.

Evidence of this change in attitude was visible at laboratory industry meetings throughout the United States in 1997. It was clear that most laboratory administrators were past the stage of outright denial. But this attitude adjustment does not mean that these same laboratory administrators will suddenly become pro-active change agents. These laboratory administrators have a habit of maintaining the status quo. Thus, it will be difficult for them to *initiate* the necessary management projects which improve the competitive position of their laboratory.

Such projects inevitably mean staff reductions. Most administrators are not yet ready to launch such actions on their own initiative. But their revised attitude towards the need to change will have a positive impact.

As hospital administrators direct that laboratory restructuring take place, these laboratory administrators and directors will respond with less entrenched resistance and obstructionism than in past years. Consequently, the overall pace of laboratory restructuring in the industry will increase from 1997 into the future.

Diagnostics Industry Entering Early Stages of Consolidation

COMMERCIAL LABORATORIES underwent consolidation. Hospital laboratories are currently consolidating. Now it is the turn of the diagnostics industry.

During 1997, **Roche Holdings, Ltd.** acquired **Corange, Ltd.**, owner of **Boehringer Mannheim, GmBh**. The acquisition made Roche the largest diagnostics company in the world.

In September, **Beckman Instruments, Inc.** purchased **Coulter Corporation**. Both companies were dominant in their market segments of chemistry and hematology, respectively. The combination of the two companies has created a powerful competitor.

These are significant events. During 1998 and 1999, there will be further mergers among various diagnostic companies. The Roche and Beckman acquisitions created fundamental shifts to the marketplace. Competing diagnostics firms must respond if they are to maintain a strong competitive presence within the laboratory marketplace.

Expect to see this consolidation activity change the way diagnostics companies package and price their products. With fewer, but larger buyers, one big difference will be the bundling of related instruments. "Per Click" pricing and similar offerings will appear in the marketplace.

As new technology enters the marketplace, it will require more capital and market clout to survive. Thus, many of the smaller diagnostics companies will be gobbled up by the diagnostics giants as consolidation proceeds.

Private Insurers Sue SBCL, Adopting Federal Lab Regs

IT IS INCREASINGLY COMMON for insurance plans to adopt Medicare guidelines as the way they require laboratories and pathologists to code and bill for private plan services. Here's a major development which promises radical change. Yet most laboratory managers are unaware of its potential impact.

In August of 1997, a group of 37 private insurers filed a lawsuit against SmithKline Beecham, claiming that the laboratory company had defrauded them by as much as $1.5 billion. The insurers base their claims upon the similar issues raised by federal prosecutors in their $325 million settlement with SmithKline. This group of insurers represents a sizeable chunk of the covered lives in the United States, so its decision to sue SmithKline is highly important.

THE DARK REPORT believes that private insurers are struggling to properly administrate claims for private services. This creates pressure to unify and streamline their processes for claims administration. They are finding it easier to use Medicare guidelines as a standard than to create and sustain their own guidelines in parallel with Medicare.

Because Medicare guidelines are designed by bureaucrats, they are already poor reflections of the free marketplace. The adoption of these guidelines by private insurers will only complicate the lives of laboratories and other providers. **TDR**

Special Report from the Pathology Income Symposium!

To Protect Pathology Profits: Understand Managed Care

CEO SUMMARY: On November 8, 1997, THE DARK REPORT convened a private symposium restricted only to pathologists. The sole purpose of this event was to identify how pathologists could preserve and enhance their income. Within the confidential setting of a plush resort in Scottsdale, Arizona, experts and pathologists dissected the market dynamics eroding pathology compensation. Strategies, tactics and knowledge necessary to maintain and increase pathology income were articulated, debated and graded. This article extracts critical knowledge provided by a managed care insider at that symposium. It is must reading for pathologists (and laboratory administrators) seriously concerned about beating the managed care beast before it devours them.

PATHOLOGISTS ARE PROBABLY the most vulnerable physician specialty within healthcare. Unlike the typical physician, pathologists neither see patients personally nor do they practice medicine in large clinic or group settings.

Another characteristic of the pathology profession compounds its intrinsic market weakness. Because they historically practiced in a hospital setting, pathologists never developed a comparable level of business acumen and experience as physicians in private practice. This leaves them exposed on matters of compensation and reimbursement. Pathologists typically lack the clout that surgeons, specialists and family practitioners can wield.

Obvious Consequences

The consequences are obvious. Now that money and economics drive healthcare, clinical skills alone are no guarantee of success. Managed care requires all physicians to develop business skills that complement their clinical expertise.

At THE DARK REPORT'S *Private Symposium On Pathology Income* in Scottsdale on November 8, experts in contracting, financial management and legal issues revealed business "secrets" unknown to most pathologists. Since managed care contracts are rapidly becoming the primary vehicle for defining provider relationships and reimbursements, that topic led off the *Private Symposium*.

Jake Dougrey, of **Pathology Consultants and Associates** in Cambridge, Massachusetts was hand-picked to lead contract strategy lessons at the *Private Symposium*. His unique career includes hospital administration and laboratory management. At the 700,000 member **Tufts Health Plans,** Dougrey was Manager of Ancillary Services. Prior to Tufts, he was involved in laboratory services at the 600,000 member **Community Health Plan**. In recent years, he's handled managed care contracting at two of the largest outreach-based pathology practices in the United States. His experience is unmatched at understanding managed care from both sides of the table.

Two Fundamental Trends

"Given that clinical integration and managed care are two fundamental trends reshaping healthcare," said Dougrey, "It follows that the contractual relationship between pathology practices and the healthcare community is now a critical success factor. But not all pathologists are willing to acknowledge this.

"These changes make it essential for all the pathologists in your group to understand how managed care fundamentally changes the way healthcare services are contracted and delivered," he continued. "Second, it is critical for pathologists to understand how managed care operates. What are the financial incentives that encourage physicians to sign such contracts? Is risk-sharing a part of the contract?

"Most pathologists and laboratory administrators will be surprised to learn that sizeable reimbursement dollars can flow to providers through the risk-sharing segments of a managed care contract. Specifically, capitation payments made at the front-end are not the only source of revenue to the provider.

"That is why it is essential that you understand the financial design of managed care contracts," he added. "The most important type of managed care plan to affect pathology will be the Medicare HMO model."

"Keep in mind that Medicare is already the dominant payer for anatomic pathology services. Depending on the location of a pathology practice, Medicare can comprise anywhere from 20% to as much as 70% of the reimbursement collected by a pathology practice.

"Because Medicare is a predominant source of pathology compensation," noted Dougrey, "I want to share with you how Medicare HMO programs incorporate risk-sharing into their contracts with hospitals and physicians. You will understand why pathologists do not get reimbursed in the same way as hospitals and physicians. It is because pathologists are invariably excluded from risk-sharing arrangements."

Medicare Fastest Growing

Dougrey noted that 40 million senior citizens are covered by Medicare. Compared to commercial health insurance, the number of Medicare enrollees is growing four times as fast. Every month 80,000 Medicare enrollees shift from fee-for-service coverage to managed care Medicare risk plans.

"There is explosive growth in Medicare risk plans," he continued. "In 1993, they covered 2.5 million lives. This almost doubled to 4.6 million by mid-1997. I want to make this point: the Medicare business, which comprises a large segment of anatomic pathology, is transforming itself at an incredible rate. Such rapid growth is why pathologists need to anticipate how their income will change as Medicare changes."

Dougrey makes a critical point for pathologists. Even though most anatomic pathology work for Medicare patients is currently reimbursed through DRGs and fee-for-service arrangements, that is quickly changing. Dougrey is correct in pointing out that pathologists wanting to preserve and enhance their income, must understand managed care and adapt to its requirements.

Premium Splits, Risk Structure

Full risk payment to Medicare HMO includes Part A and B. Risk group receives 95% of county specific rates.

Premiums distributed as follows:

20% To Managed Care Company: responsible for administration, marketing and information.

45% To Hospital Fund: (risk shared equally between hospital and physicians.) Fund pays for inpatient, ER, outpatient surgery, home health, skilled nursing facilities.

35% Medical Fund: (physician group at full risk for surplus and loss.) Fund pays all office, ancillary, Part B specialists (outpatient and inpatient).

"Given the importance of Medicare reimbursement to the typical pathology practice, I would now like to explain the details of a Medicare risk plan and how its provider contracts are structured. No pathologist will negotiate a successful win-win contract unless they understand the structure of the risk plan.

"First, the Medicare HMO gets a flat monthly payment from HCFA which includes Part A and Part B," said Dougrey. "The risk group receives 95% of the 'county specific rate,' based on which county the enrollee enrolls and lives in. County specific rates vary widely. For example, in New York City and some Florida counties, the rate may be as high as $800 per month per individual. Rural counties in Arkansas and Mississippi can be as low as $300 per month.

"Let's dissect the Medicare risk plan," he said. "My model is based on a typical Medicare HMO arrangement, offered by the national managed care companies. Premium dollars from Medicare are distributed in three ways. First, 20% of the dollars come off the

top and go to the managed care company. This pays for administration, marketing, information services, etc."

Hospital Fund Next

"Next, the hospital fund gets 45%. Claims are paid from this prepayment amount. Risk is shared equally between the hospitals and physicians. The hospital fund pays for inpatient ER, outpatient service, home health, and skilled nursing facilities," he noted. "Keep in mind, Medicare requires that a certain portion of these monies go to pathologists for administrative directorship of the laboratory. Radiologists, anesthesiologists, and ER physicians are also compensated from this pool of funds.

"The final 35% goes to the medical fund. This is controlled by the physicians. It covers their services, along with some 15 to 16 ancillary services. Part B specialists (inpatient and outpatient) are included. This 35% pool is full risk. It means that 100% of any surplus is kept by them. It also means that 100% of any losses are absorbed by them.

Sweetheart Portion

"From my perspective, the sweetheart portion of this risk-sharing is the hospital pool," noted Dougrey. "Physicians share this equally with the hospital. Although there are generally several hundred physicians in this pool, I have seen arrangements with as few as 15 doctors to share the risk pool with the hospital.

"Simple arithmetic shows us the lucrative potential of risk-sharing. If there are 1,000 enrolled members and monthly payments are $500 per month, then a total of $6 million per year will flow through the HMO. Right now, the Boston rate is about $500 per month. The table (see sidebar this page) shows how payments for the 1,000 enrollees are distributed."

Dougrey continued. "Calculate the numbers for the medical fund. Assume the 1,000 enrolled members in our example are covered by one medical group. In the real world, it is common for a primary care physician to have five or six hundred Medicare patients in their practice.

"In fact, physicians with large Medicare patient populations are the ideal targets for Medicare HMOs. These doctors have established relationships with their patients extending back many years. When the Medicare patient opts for the HMO product, there is no switch in physician or patient records. Plus, the risk-sharing design of the Medicare HMO gives the physician a motive to convert his Medicare patients from fee-for-service to managed care.

"Back to the medical fund. It is designed to pay 70% of the premium dollars to specialists, even though the risk is carried by the primary care physicians carrying the contract. What is the logical thing for these physicians to do? They approach the specialists to negotiate lower rates than Medicare.

"This is a critical concept to understand," emphasized Dougrey. "HCFA is reimbursing the Medicare HMO at 95% of the prevailing rates in that county. So physicians participating in the medical risk pool must somehow get the specialists to work for less than the Medicare fee schedule.

Medicare Risk Plan Premium Distribution

Assume $500 per beneficiary per month and 1,000 enrolled members. Premiums distributed as follows:

Managed Care Company (20%)
$100,000 monthly $1,200,000 yearly

Hospital Fund (45%)
$225,000 monthly $2,700,000 yearly

Medical Fund (35%)
$175,000 monthly $2,100,000 yearly

FUND TOTALS
$500,000 monthly $6,000,000 yearly

"Ophthamology demonstrates how money is spent spent on specialists. A typical ophthalmologist generates, on a fee-for-service basis, almost $20 per month for each Medicare recipient living in their county. For this reason, contracting physicians in the medical risk-sharing pool want to negotiate discounted pricing from ophthalmogists.

"It works the same for radiology and pathology," said Dougrey. "Compare the cost of radiology against pathology for a commercial population. Radiology costs are double those of pathology until people hit 62-years old. By the age of 70, pathology expenses equal radiology expenses.

"Within the Medicare risk pool, it becomes clear that pathology costs are three to five times those of a commercial population. While handling ancillary contracts at the managed care plans where I worked, I frequently saw data which showed radiology and pathology expenses of $14 to $18 per member per month for each specialty! This is a big number compared to the total capitated payment coming to the primary care physicians in the risk pool. It is why pathologists are asked to accept reimbursement at less than Medicare rates.

Risk Pool Physicians

"This brings us to another critical strategy used by the risk pool physicians," he said. "We now understand why they want to negotiate fees which are less than Medicare with specialists, including pathologists. But there is another essential business requirement to make the risk pools work. That requirement is 'eliminating risk.'

"Physicians participating in the medical fund risk pool can limit their exposure by getting specialists to accept capitated reimbursement instead of discounted fee-for-service. Any specialist accepting capitated reimbursement is assuming risk.

"This twin process of negotiating lower fees and minimizing risk through capitated reimbursement arrangements, makes it clear why large regional and national companies make good partners for the subcontracts," added Dougrey. "Why? Because their sophisticated organization allows them to reduce the cost of services. They are also more sophisticated in dealing with capitation reimbursement. Remember, once a specialist accepts a capitated reimbursement plan, utilization control now rests with the specialist."

Radiology costs are double those of pathology until people hit 62-years old. By the age of 70, pathology expenses equal radiology expenses.

After Dougrey's explanation of how incentives direct the contracting physicians' behavior in the medical risk pools, he turned to the hospital fund. "Reducing bed days is what drives the hospital fund's risk sharing component. Compare the number of bed days per 1,000 beneficiaries. New York City, at 5,000 bed days, is almost twice the national average of 2,600 bed days. But Southern California has only 1,000 bed days. New York City, up until 1997, had a very different payment mechanism for hospitals than Medicare DRGs. Southern California has extensive experience with Medicare HMOs.

"With hospitals and physicians sharing the risk in the hospital fund segment, what business strategies are used to eliminate risk and maximize reward?" asked Dougrey. "Simply put, it is a switch away from Medicare DRGs, and putting patient reimbursement onto a per diem arrangement.

"Under DRGs, pressure for utilization management came from the hospital. The drive was to get the patient out as soon as possible. So hospital administration and nurses managed utilization based on length of stay."

"By dropping DRGs and moving to a per diem, and by including physicians in the risk pool with the hospital, there is a significant change in case management and utilization review. Incentives now draw physicians directly into review of the hospital utilization."

Hospital Bed Day Savings

"Let's look at the arithmetic," he continued. "Go back to New York City, with 5,000 bed days per 1,000 Medicare beneficiaries. Shave 100 bed days off that number and what happens? Assume a per diem of $1,000. At the end of the year, the hospital and the physicians in the risk pool would split $100,000.

"In my experience, I've seen groups with 2,000 members and the surplus in the first year was $600,000. This was split equally between the hospital and physicians. So the medical group got $300,000 at year-end from its split of the hospital risk pool. This is on top of whatever they earned from their medical pool, comprised of the capitated rate and the risk pool."

Financial Impact

"By understanding the financial impact of these business arrangements," said Dougrey, "you can see the worthwhile incentives which attract the primary care physicians' participation in the medical pool of a Medicare HMO.

"I believe we will see these Medicare HMOs continue to grow," he said. "For pathologists, this is a key insight. If you look at total population in areas of the United States where managed care is well-established, maybe only 10% to 20% of the population is left to push into managed care plans. In markets such as these, the managed care plans already recognize that marketing to this segment steals patients away from other plans.

"This is why managed care plans see Medicare HMOs as a great growth opportunity. They take 20% off the top and capitate the rest with hospitals and physicians. Plus, as these Medicare

Pathologists Should Question Future

"WITHIN THE PATHOLOGY PRACTICE that I represent, we continually ask the following questions," said Jake Dougrey of Pathology Consultants and Associates. "Who is our customer today? Who will be our customer in three years? How do we align our incentives with these emerging customers? I recommend that your pathology practice discuss these five questions as they develop a viable business plan:

"***One***, does the pathology practice have a business structure that supports future developments in the healthcare marketplace?

"***Two***, is the pathology practice able to serve patients in both the inpatient and outpatient populations? I look at the **AmeriPath** business model and I feel strongly that they realized this trend in the pathology marketplace. They are acquiring pathology practices that are anchored in the hospital but also have significant outpatient revenue. Thus, they can serve both patient populations.

"***Three***, can your pathology practice partner with hospitals, IPAs, PHOs, specialists, medical groups or other pathologists? This is an open-ended question, but it is precisely the strategy that you and your colleagues should debate and develop.

"***Four***, what happens to Part A pathology payments in a per diem environment? Every time contract renewal discussions occur and the hospital administrator tells you his DRGs are decreasing and his Medicare is declining, you must be prepared. Your negotiating tactic must include recognizing the shift to per diem and the risk share which benefits the hospital .

"***Five***, who represents my contract in contract negotiations? Some pathologists do it themselves, some pathologists have shared contract people and some pathologists leave it to the hospital to represent them in contract negotiations. It may be time to change the way your pathology practice is represented in contract negotiations."

HMOs become bigger, the managed care plans develop more sophistication and expertise at putting them together and making them work.

"For physician groups, the same is true. As they grow bigger, they gain more experience and capability to serve these Medicare HMOs. This is one reason why you see physician groups establishing their own systems, including relationships with specialists, nursing homes and outpatient therapies."

Physician Incentives

"Obviously you can see one consequence of this. Physicians with risk in the medical pool have a direct incentive to move the patient out of the hospital and into the outpatient setting. For pathologists, this key insight reveals how and why Medicare managed care plans will direct patients away from the hospital, and hospital-based pathology practices.

"These are the reasons why pathologists must respond to the threat of Medicare HMOs," concluded Dougrey. "The shift away from hospital-based pathology is now taking place.

"To develop effective business strategies, I recommend that pathologists use five market drivers to frame their plan. First, remember that Medicare managed care is considered a growth opportunity by managed care plans and physician groups who understand population demographics.

"Second, it is the incentives, the risk pool pay-offs, that are the larger deal in a Medicare HMO provider contract. The economics make better sense when the potential rewards of the risk pool are understood.

"Third, pathologists must demonstrate value to all their customers. Be it a medical group, an IPA, or a PHO, success depends on showing these people how you bring value to their part of healthcare.

"Fourth, provide coverage to the entire population, to in/outpatient and physician office patients.

"Five, strategic business partners will be critical to success in this effort. Who will you align yourself with? It is essential to find appropriate strategic partners.

"Six, actively participate in structuring payment arrangements. Rather than taking what's given to you, seize the initiative and propose reimbursement for pathology services in a different structure. If you have demonstrated added-value, then you are better positioned to get a more generous reimbursement arrangement." TDR

(For further information, contact Jake Dougrey at 617-252-6880.)

DATE SET BY FDA PANEL TO REVIEW NEOPATH'S AUTOPAP® SYSTEM FOR PRIMARY SCREENING

In less than 30 days, the FDA will convene a panel to review **NeoPath, Inc.'s** amendment to its PreMarket Approval (PMA) Supplement for the AutoPap System® as a primary screener.

Scheduled for January 28, 1998, the hearing involves the FDA's Hematology and Pathology Devices Panel. Should the review process lead to FDA approval of the AutoPap System for primary screening, it will mark the first time that an automated cytology system has approval for primary screening.

Beginning in 1998, CPT codes covering automated cytology are now available. That helps all three automated cytology companies currently offering products in the marketplace. Should NeoPath gain authorization to market AutoPap as a primary screener, then all the pieces are in place for this technology to demonstrate its economic and clinical efficacy through performance in day-to-day clinical use.

Louisiana Reference Lab Purchased By Dynacare

Hospital system sells consolidated laboratory to access capital value of outreach business

CEO SUMMARY: General Health System of Baton Rouge decided to "cash in" the capital value of its consolidated laboratory organization by selling it to Dynacare. It will use the money for other corporate projects. This sales transaction validates that there is still considerable value to a profitable laboratory outreach program.

BATON ROUGE-BASED **Louisiana Reference Laboratories** has been acquired by **Dynacare, Inc.** of Toronto, Canada. It is Dynacare's first laboratory operation in Louisiana.

Louisiana Reference Laboratories (LRL) is one of the largest commercial laboratory operations in the state. It was owned by **General Health System**, an integrated healthcare system in Baton Rouge that operates its own HMO. Besides an extensive outreach program, LRL provides testing to **Baton Rouge General Hospital** and **Baton Rouge General Medical Center** from its core laboratory in Baton Rouge.

> ***"Dynacare is here to stay. Our company is committed to expansion in Louisiana and the surrounding states."***
>
> ***Osama Sherif***
> *Dynacare, Inc.*

Motives of the buyer and seller demonstrate that outreach laboratory volume still has considerable market value. As the seller, General Health System liquidated a capital asset. It intends to use the money from the sale of Louisiana Reference Laboratories to strengthen its clinical service infrastructure in Baton Rouge. In so doing, General Health System shows that it appreciates the capital value created by a dynamic outreach program.

As the buyer, Dynacare intends to use LRL as the springboard for a major marketing program in Louisiana as well as the neighboring states of Mississippi and Arkansas. Dynacare believes it can generate substantial operating profits by building its outreach business in the multi-state region.

"LRL is dominant in its primary market," stated Osama Sherif, Executive Vice President of Dynacare U.S. "This is consistent with our strategy of opening new markets by acquiring a dominant laboratory or partnering with an established laboratory in that area.

"From a competitive perspective, LRL has no entrenched competition within Louisiana," continued Sherif. "None of the national laboratories operate a sizeable laboratory facility in the state. Because LRL is viewed as a local provider, we feel that will provide us a sizeable advantage in our sales efforts."

As a private transaction, terms of the sale were not revealed by either the seller or the buyer. It is estimated that Louisiana Reference Laboratories generates about $25 million per year in revenue. Of that total, about 75% comes from outreach and 25% would come from hospital in/outpatient work. Rumors place the sales price at approximately $15 million. Dynacare will provide testing to the hospitals under a seven-year agreement with General Health Systems.

Currently the President of LRL is Steven R. Shumpert. Under Shumpert's leadership, LRL grew steadily and avoided many of the management mistakes made by the national laboratories. To the disappointment of Dynacare, Shumpert tendered his resignation. He will stay during the transition period and has not stated his future plans.

There is an interesting historical footnote to Louisiana Reference Laboratories. It originally was a joint venture between the hospital and **International Clinical Laboratories** (ICL) in the 1980s. Sometime after ICL was purchased by **SmithKline Beecham Clinical Laboratories**, General Health Systems exercised its option and bought out SmithKline's interest. From that time forward, LRL operated as an independent laboratory.

For Dynacare, the acquisition of Louisiana Reference Laboratories is the first step in a regional strategy. "Already we operate in Houston, through our partnership with **Hermann Hospital**," explained Sherif. "We are discussing partnership or acquisition opportunities in both Arkansas and Mississippi."

According to Sherif, Dynacare's business plan has three components. "One, we will build the operational base to support our regional goals through acquisitions and joint ventures. Two, we will develop an expanded sales and marketing program in our service area. Three, we will construct a new core laboratory in Baton Rouge to improve our operational flexibility."

Dynacare is a laboratory to watch. Most of their laboratory divisions and joint ventures seem to be growing. As many hospital lab administrators know, Dynacare is pursuing joint venture opportunities in a number of cities. Announcements of other deals may be just around the corner. TDR

(For further information, contact Osama Sherif at 416-322-2318.)

Dynacare Growing Rapidly in the U.S.

Since entering the United States in 1994, Dynacare has steadily expand- ed its activities. It follows a strategy based on acquiring strong regional labs or partnering with hospital laboratories.

Dynacare Cheyenne Laboratories; Cheyenne, WY: Acquired in 1994, owned and operated by Dynacare.

Dynacare Skagit Valley Laboratories; Mt. Vernon, WA: Acquired in 1994. Owned and operated by Dynacare.

Dynacare Laboratories; Seattle, WA: Acquired in 1995. Owned and operated by Dynacare. Serves **Swedish Hospital** under a long term contract.

Dynacare Hermann Laboratory Services; Houston, TX: Partnership with Hermann Hospital. Launched in September, 1995.

Dynacare Ellis Laboratory Services; Schenectady, NY: Partnership with **Ellis Hospital**. Launched in June, 1996.

United/Dynacare; Milwaukee, WI: Partnership with **Froedtert Memorial Lutheran Hospital's** United Regional Medical Services Division. Agreement effective August 1, 1997.

Louisiana Reference Laboratories; Baton Rouge, LA: acquired Dec. 1, 1997.

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

AmeriPath, Inc. is at it again. On December 19, company officials announced the acquisition of two more pathology practices. The practices are **The Dermatopathology Laboratory** in Pittsburgh and **Laboratory Physicians** in Jacksonville. More acquisition announcements should be expected from AmeriPath. Growth by acquisition will be its dominant strategy during the next several years.

Managed care giant **Oxford Health Plans, Inc.** disclosed that it would post a fourth quarter loss of $120 million. This comes on the heels of last quarter's $78.2 million loss. Internal problems were greater than originally announced, causing company officials to increase write-downs.

MORE ON:...HMOS

Three Massachusetts HMOs are caught in an interesting paradox. Profits are marginal even as they increase the number of enrollees. **Harvard Pilgrim Health Care**, **Tufts Health Plans**, and **Falcon Community Health Plan** all reported slim or no profits for third quarter. At the same time, enrollment was up by 186,000 at Tufts, 116,000 at Harvard Pilgrim and 12,000 at Falcon. If the three plans are struggling to make money, increasing the number of enrollees may only make it more difficult to return to profitability.

LAB ACQUISITION COMPLETED

Laboratory Specialists of America completed its acquisition of the drugs of abuse testing operations of Arkansas-based **Accu-Path Medical Laboratory**. The sale involved around $500,000 in testing. Laboratory Specialists has been quietly acquiring small chunks of toxicology business and posting steady profits. It is a NASDAQ-traded stock, and its symbol is LABZ.

More evidence that automated cytology technology is gaining acceptance comes from announcements by **Cytyc Corporation** of Boxborough, Massachusetts. According to the company, its ThinPrep® Pap Smear test will be covered by California's Medi-Cal Program. This is the largest Medicaid program in the United States and covers about 5.5 million people. Cytyc also announced that **Harvard Pilgrim Health Care** will cover ThinPrep procedures for its 1 million members.

ADD TO:...AUTOMATED CYTOLOGY

Now that CPT codes are available for automated cytology procedures, expect a steady stream of announcements by individual healthcare plans stating that they will reimburse for these procedures. All three of the major players, Cytyc, **NeoPath, Inc.** and **Neuromedical Systems, Inc.**, are hoping that Medicare will eventually authorize reimbursement for automated cytology procedures. However, no one expects quick action by Medicare on this issue.

SAVE THESE DATES:

May 12-13, 1998. That's when THE DARK REPORT's Third Annual *Executive War College On Laboratory Management* will convene in New Orleans, Louisiana. Our editor is scheduling several exciting case studies of laboratory innovators. Keep watching for further details.

That's all the insider intelligence for this report. Look for the next briefing on Monday, January 19, 1998

UPCOMING...

- ***THE DARK REPORT's Laboratory and Pathology "Movers & Shakers" for 1998.***
- ***Criminalization of Healthcare by the Feds: Laboratory Executives Should be Concerned.***
- ***Academic Hospital Launches Laboratory Outreach Program...and Succeeds!***
- ***1998 Predicted to be Record Year for Joint Ventures Between Hospital Labs and Commercial Laboratories.***