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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

Restricted information, see page 3

COMMENTARY & OPINION by...

R. Lewis Dark
Founder & Publisher

Payer Contracts and Labs' Access to Patients

ONE OF THE MOST SIGNIFICANT TRENDS IN RECENT YEARS is the exclusion of community lab companies and local pathology groups from a growing number of health insurer networks. In simplest terms, if a community lab is denied network provider status by the major payers in its region, it loses access to the patients it needs to maintain clinical excellence and financial stability.

Given the importance of patient access to the entire profession of laboratory medicine (not to mention patients and the often short-sighted and short-term actions of health insurers), this issue of THE DARK REPORT offers you news about current developments in managed care contracting in the states of Pennsylvania and Florida. It provides you with context and understanding that you can use to better position your laboratory during negotiations to renew managed care contracts.

One truth of the decade of the 2000s was that the managed care contracting strategies used by the two national laboratories did relatively little to improve their overall market share in most cities and towns. Physicians continued to refer specimens to local labs, even if they were not in network. Payers typically reimbursed out-of-network labs.

That is no longer true. On one hand, the two national labs have demonstrated a willingness to pursue a managed care contract by offering that payer extra-low pricing in return for excluding their national competitor (and as many community labs as possible) from that payer's provider network.

On the other hand, health insurers are now more aggressive at pushing out of their networks those hospital labs that still use inpatient pricing for outreach test claims. Additionally, more payers are now willing to accept a national lab's deeply-discounted pricing in exchange for excluding competing labs from their networks.

All of these elements can be found in the stories and analyses we present to you in this issue of THE DARK REPORT. You should use them as you work with your lab's executive team to develop more effective managed care contracting strategies for your lab organization. In many respects, the clock is ticking on the financial viability of the nation's community labs. Many observers believe that, as the nation's two largest laboratories continue to squeeze their lab competitors, the end game may well be a national duopoly in clinical lab testing. TDR

Philly Blue Cross Contract: LabCorp In; Quest Out

Following an aggressive bidding war, IBC selects LabCorp and boots Quest Diagnostics from its network

CEO SUMMARY: Independence Blue Cross in Philadelphia decided to select Laboratory Corporation of America for its new eight-year managed care contract that took effect on July 1. However, the real story is the aggressive bidding war between the two national labs. Sources say LabCorp bid an aggressively low price of between $1.00 to 1.60 per member per month for routine lab tests, and, in exchange for that low rate, IBC agreed to exclude Quest Diagnostics from its network.

PHILADELPHIA IS KNOWN AS THE CITY OF brotherly love. But this summer, in this city, there is not much love between the two blood brothers.

On July 1, **Laboratory Corporation of America** took over the contract to serve members of **Independence Blue Cross** (IBC) in eastern Pennsylvania. This dislodged **Quest Diagnostics Incorporated**, which had held the IBC contract for seven years or more, according to sources.

These sources said that, over the next eight years, the IBC contract is estimated to be worth between $120 million and $150 million per year. It is a major managed care contracting coup for LabCorp, since IBC is believed to have more than 2 million members in Pennsylvania and more than 3 million nationwide, according to published reports.

During negotiations in the fall and early winter of 2013, LabCorp reportedly bid an aggressively low price for routine lab tests, a price that was attractive enough to win the bidding war against Quest Diagnostics for the IBC contract, sources said. Quest had been getting $3.75 per member per month for routine tests and even though Quest was willing to go lower, it was not willing to go as low as LabCorp's offer of possibly less than $1.00 to $1.60 PMPM, sources told THE DARK REPORT.

In exchange for offering such a low PMPM rate, LabCorp insisted that Quest Diagnostics be eliminated from the IBC network and IBC agreed, sources said. For this article, THE DARK REPORT interviewed lab directors and contracting executives in Pennsylvania and the Northeast. All asked to remain anonymous.

Managed care contracting executives from a number of different lab companies have told THE DARK REPORT that the bidding wars between the two national labs for important managed care contracts are intensifying. More importantly, these observers believe that both national labs are employing aggressive contracting strategies intended not to just win them the business, but to exclude independent and clinical labs from a health insurer's network.

Market Strategy Precursor

That is why LabCorp's play to win IBC's Philadelphia regional market—even while insisting that Quest Diagnostics and perhaps other labs be excluded from the network—is likely to be repeated in other markets nationwide, sources said. Based on the IBC agreement and some other contract negotiations, multiple sources told THE DARK REPORT that the two national labs will become more aggressive at using managed care contract negotiations to eliminate lab competitors from health plan networks.

"This new strategy differs from what we've seen in past years," stated one lab director in Pennsylvania. "Typically, a lab would negotiate with a payer because it wanted to get into a market or obtain preferred status. It might fight just to stay in a contract. But in past years, we didn't see national labs telling payers to exclude their lab competitors as one of the terms of the managed care contract.

Targeting Competitors

"During negotiations in the past, labs would make the case to health insurers that their service was superior," the lab director said. "Or they would offer special pricing in exchange for developing special programs for certain patients.

"Labs knew that physicians wanted to have a choice among lab providers," the lab director added. "But now the game is for the two national labs to put other labs out of the network. The big guys dangle lower rates to a health plan in exchange for an exclusive contract.

"This tactic hits below the belt because now the winning lab no longer needs to compete on quality, service, or turnaround time," emphasized this lab director. "With no other lab in the payer's network, the winning lab is no longer obligated to perform to a high standard. And, once you lose your competitive edge, then service, quality, and attention to physician satisfaction and patient care go down. Today, these contracts are all focused on price."

Narrowing the Network

Health plans have found that narrow networks help them to control costs and the national lab companies seek to take advantage of this strategy. "This appears to be the main strategy of the bigger labs," noted a managed care VP at another lab. "As part of narrowing the network, a big lab will tell the health plan they can cut out-of-network spending by eliminating other labs as contract providers."

A strategy like this creates a challenge, though, because it frustrates the doctors who want choice. For example, doctors in the Philadelphia market were mostly happy with Quest Diagnostics, sources said. "When doctors are unhappy, they may continue to use out-of-network labs and that drives up spending," a lab director commented.

To control out-of-network leakage, representatives of LabCorp and IBC are expected to begin visiting those physicians who are not using the in-network labs. During these meetings, the representatives will ask what the doctors want from LabCorp in terms of service and quality. Then they will aim to deliver what the physicians want.

"But if the doctors still don't stop sending tests to the out-of-network labs, then IBC may start to consider financial penalties," a lab director said. "Further, in some cases, IBC may eliminate doctors

Did Independence BC Contract Talks Revolve Around Only One Key Element: Lab Test Pricing?

FOR THE PAST SEVEN YEARS Quest Diagnostics Incorporated had the contract to serve members of Independence Blue Cross (IBC) in Southeastern Pennsylvania. It was getting a decent rate for routine testing of almost $4 per member per month, sources told THE DARK REPORT.

Quest also had an extensive list of esoteric, genetic, and molecular tests that were carved out of the PMPM rate. For these tests, IBC paid Quest on a fee-for-service basis, sources said. Getting FFS payment for these higher-cost tests is the key to making low PMPM rates for routine tests work, the sources said.

Under a Medicare Advantage contract with Quest Diagnostics, IBC expected to pay about $8 million to $9 million per year for lab testing. However, because Quest continually added more esoteric, genetic, and molecular tests to its menu, IBC's lab costs rose, sources said. In a recent year, the total that IBC paid to Quest for that portion of the lab work was almost double—at about $15 million—from what it expected to pay, a lab executive said.

These sharp increases in payment are what opened the door for LabCorp to begin contract discussions with IBC last year, multiple sources said.

"Quest Diagnostics had its sales reps increase their efforts to detail doctors about molecular and esoteric tests, because these tests would be billed off capitation and as fee-for-service claims," said one lab executive. "In fact, that's what Quest and LabCorp do. They essentially discount deeply the routine tests to the payers. Then they go into the doctor's offices and upsell those doctors by pushing the molecular and esoteric versions of tests. The next thing you know, the health plan is spending much more than what it should be spending."

Once LabCorp saw an opening with IBC, its sales team initially offered a rate that was lower by 30¢ to 40¢ PMPM, another executive said. "They can offer this modest savings off the capitated rate for the routine tests because LabCorp is the king of upselling the esoterics and other tests. In our market, we think they are more effective at getting doctors to order more molecular tests than Quest Diagnostics.

Contract Renewal Talks

"During the negotiations with IBC, Quest wouldn't go below $3 PMPM, at least at first," noted a different lab manager from Pennsylvania. "But then at one point, we heard that Quest offered a cap rate that was below $2 and it planned to make up the difference with esoteric and other higher-priced tests. Those esoteric tests can total about 50% or more of a health plan's total spending and that's all billed to the payer at fee-for-service rates."

When LabCorp offered a cap rate of $1.60 PMPM or less, sources speaking to THE DARK REPORT were not clear if IBC even went back to Quest for another bid. What is known is that IBC took the lower PMPM price and agreed to LabCorp's demand to eliminate Quest from the IBC network, sources said.

The IBC contract positions LabCorp to greatly increase its share of the greater Philadelphia market. "Before losing the IBC contract, Quest was probably controlling as much as 80% of the $120 million to $150 million that IBC was paying yearly for lab testing," observed one source. "Now Quest may struggle to hold on to as little as $20 million yearly of that market. That's a huge hit for Quest. At the same time, LabCorp is primed to expand its market share of the Philadelphia metro."

from the network. Independence Blue Cross could also hit physicians with financial penalties in 2015."

Some of the Pennsylvania lab executives interviewed for this article said they are still in the IBC network. However, they

observed that some patients were confused early this summer about which labs were in network and which were out of network. IBC sent a letter to members dated June 1 that said LabCorp would be the network laboratory services provider.

Market Confusion

IBC's June 1 letter to physicians said: "Independence Blue Cross (IBC) has selected Laboratory Corporation of America Holdings (LabCorp) as its primary provider of outpatient laboratory services, effective July 1, 2014. Also effective July 1, Quest Diagnostics will no longer be included in the IBC network. In addition to LabCorp, all other laboratories currently in our network will remain as in-network providers with the exception of Quest Diagnostics."

Even though the letter is clear that other labs remain in network, some sources said that a significant number of patients and physicians believed all work had shifted to LabCorp. This was such a problem that some labs felt the need to raise awareness of their network status.

In an effort to retain their customers, several clinical labs in Southeastern Pennsylvania took out advertisements in newspapers. These ads explained that the labs remained in the IBC network and would continue to serve their physicians and patients in the five counties of Southeastern Pennsylvania: Bucks, Chester, Delaware, Montgomery, and Philadelphia.

Contract Renewal Concerns

While these other labs were allowed to remain in the network for now, lab directors and contracting executives worry about what may happen when their labs' contracts come up for renewal.

"At the moment, we are still in the IBC network," said one lab executive. "I don't know what's going to happen when our contract renews but IBC has to give us notice before that date. Few labs of any size can survive on PMPM rates of $1 to $1.60 or so."

"Actually, we anticipate that IBC will keep regional labs in its network for a while longer just to make the doctors happy," predicted another lab manager. "I think there are two reasons why this will be true.

"First, LabCorp has a much smaller presence in Philadelphia and Southeastern Pennsylvania than does Quest Diagnostics," she continued. "That is why IBC has probably allowed smaller labs in the area to stay in the network. It needs their phlebotomy sites and existing service infrastructure, which LabCorp does not have today.

"Second, IBC and LabCorp will have their hands full working with large numbers of physicians who must make the time-consuming and unwelcome switch from Quest to LabCorp," she added. "That is another reason why IBC probably has left the local labs in the network. But many of us are concerned that once IBC and LabCorp have made the transition under this new contract, there will come a time when the local labs will find themselves excluded from the network, leaving only LabCorp."

Will Physicians Switch Labs?

There is the larger question of whether the physicians will want to refer tests to LabCorp. It will take time to answer that question. During the seven years of Quest's most recent contract with IBC, it had 50 patient service centers and a clinical lab in Horsham, just miles outside of the Philadelphia City Center. Its quality, service, and TAT made it a tough competitor, lab directors said.

Conversely, local sources stated that LabCorp must hustle to open PSCs and will suffer some because of a longer turnaround time. That is because it sends specimens out of state, sources said. As a result, physicians have not been getting the same day or next day results they received from Quest Diagnostics, several lab directors said. TDR

—Joseph Burns

In This Philadelphia Story, LabCorp Uses 2007 Script

As with UHC pact, LabCorp offered low rates and Quest was excluded from IBC's network

CEO SUMMARY: There's a managed care contracting playbook that seems to be working better for Laboratory Corporation of America than it does for Quest Diagnostics Incorporated. On July 1, LabCorp became the exclusive national lab provider for Independence Blue Cross of Philadelphia. For the past seven years, this contract had been held by Quest Diagnostics. These contract negotiations offer a window into the evolving contracting strategies of the national labs.

TO WREST AN IMPORTANT MANAGED CARE CONTRACT away from its major competitor, **Laboratory Corporation of America** recently employed a strategy it had used successfully seven years earlier against **Quest Diagnostics Incorporated**.

In 2007, LabCorp won an exclusive, 10-year national contract from **UnitedHealthcare**. As part of that agreement, Quest Diagnostics was excluded as a network provider. *(See TDR, October 16, 2006, and February 19, 2007.)*

Now LabCorp has taken another contract from its rival, Quest Diagnostics, in an almost identical manner. This time the prize was the large contract from **Independence Blue Cross** in Southeastern Pennsylvania. The contract could be worth between $120 million and $150 million annually for 2 million IBC members in Pennsylvania and more than 3 million members nationwide, sources said.

During its investigation into this contract award, sources told THE DARK REPORT that LabCorp followed almost the identical playbook it used in 2007. LabCorp pursued three elements in this new agreement with IBC. First, it offered an aggressively low per-member-per-month price for routine tests. Second, it worked to carve out esoteric tests from the PMPM contract price so it would be paid for these tests at fee-for-service rates. Third, Quest Diagnostics was excluded from the IBC network.

This is similar to what happened in 2007 when LabCorp took the national contract with UnitedHealthcare and Quest was excluded as a UHC provider Multiple sources contributed to this story and the preceeding story on pages 3-6. All sources asked to remain anonymous.

New Contract Strategies

This latest managed care contract award has aspects that are consistent with other payer contracts negotiated in recent years that involved one or both of the national lab companies. As most regional labs are learning, the strategies used by the national labs today are based on offering deeply-discounted prices for routine testing while leaning hard on the payer to exclude the winning national lab's pri-

mary competitor and as many as possible of the winning company's lab competitors from the insurer's network.

However, narrow networks didn't happen with the IBC contract award, just as it didn't happen with the UnitedHealth contract in 2007. Both health insurers recognized that LabCorp needed time to expand its patient service centers and other infrastructure in key cities and regions (areas where Quest Diagnostics had extensive service infrastructure). Thus, both payers wanted to keep other regional labs in their networks so that doctors would be happy with their choice of lab providers.

There are two more similarities in the story of the IBC contract in this year and the UnitedHealthcare contract in 2007. First, in each set of contract negotiations, while LabCorp was offering a very low PMPM rate for routine tests, Quest Diagnostics was unwilling to reduce the price it wanted from the payer in both negotiations, sources said.

Second, sources say that, with both insurers, as the time to renew the existing contract approached, business relations between Quest and the health insurers were strained at best. This was all the opening LabCorp needed to get its foot in the door and push it wide open with each payer.

Prospects Looked Dim

Relative to the IBC contract, multiple sources have told a similar story that runs along these lines: Last fall, there was talk at Quest's headquarters in Madison, New Jersey, that the IBC contract was up for renewal and that the prospects for retaining the largest contract in Pennsylvania were not good.

"When a contract comes up for renewal, it makes everyone nervous in the lab business," stated one source. "At Quest, the talk was that there would be negotiations with IBC over the fee schedule. That's never a good sign. Further, before the renewal was announced early this year, there was talk that LabCorp was negotiating and was interested in getting Quest Diagnostics eliminated from the network."

In 2007, LabCorp had offered UHC a very low rate for routine tests. Last fall, it did the same in negotiations with IBC. In that way, what happened with UnitedHealthcare happened again during the negotiations with IBC, sources said. And, there was the additional blow that Quest Diagnostics found itself excluded as an in-network lab for UHC members in 2007 and again this year for IBC members.

Addressing Leakage

One unknown aspect of the IBC contract is whether LabCorp is on the hook to reduce out-of-network spending (called leakage). During the negotiations with UHC in 2007, it is believed that LabCorp had a clause in the contract that called for the lab company to guarantee that it would move a target amount of leakage back into the network, or it would pay the difference.

What is known on this point is that, for its part, IBC is attempting to curb out-of-network spending by sending out-of-network reimbursement checks directly to the patient. As a consequence, the out-of-network lab now must chase the patient to collect its money. Sources said that the out-of-network lab doesn't even get an EOB from Independence Blue Cross. Rather, IBC sends the EOB directly to the patient to satisfy state law.

Does a managed contract award like this make a difference in market share? There are rumors on the street that since the July 1 effective date of this contract, patient requisitions have increased by 6,000 per day for LabCorp, with a comparable decline seen at the Quest Diagnostics lab in Horsham, Pennsylvania.

At $40 per requisition, that would represent a swing of about $60 million per year in revenue. However, the question is, at such a low capitated rate, will LabCorp be able to make money on the Independence Blue Cross contract ? TDR

—Joseph Burns

Is the Strategy Now to Bid Low on Cap Rates, Then Upsell Docs to Order More Esoteric Tests?

IF PAST IS PROLOGUE, then perhaps LabCorp's next moves can be anticipated. Back in 2007, to offset the meager income it got from UnitedHealthcare's deeply-discounted PMPM rate for routine testing, LabCorp boosted its sales program to encourage more physicians to order larger volumes of esoteric tests that were reimbursed at higher fee-for-service rates.

Competitors to LabCorp watched this element of LabCorp's strategy unfold. These sources say that, with the UHC contract in hand, LabCorp instructed its sales team to go into physicians' offices and detail those doctors on why, how, and when they should order more sophisticated esoteric tests over some of the traditional assays that are still clinically useful, but were reimbursed as part of the PMPM capitated rate.

This was a two-pronged sales strategy. One prong called for the sales reps to show physicians ways that they could "replace" a traditional routine test (paid by UHC in the PMPM capitated rate) with a more sophisticated esoteric test (paid by UHC on a fee-for-service basis). The other prong called for sales reps to introduce new esoteric tests to physicians and show how these tests could help provide advanced care to the patient.

New Esoteric Tests

This sales approach represents a new twist on the classic definition of "pull through," where the lab uses its managed care contract status to get into physicians' offices and gain access to the Medicare and other fee-for-service lab referrals. In this new twist, the lab is using a low cap rate for routine testing as a way to win the payer contract. Then the lab can upsell physicians to expand the overall types and volumes of esoteric tests they order for their patients that are reimbursed at fee-for-service rates.

"There's a lot of money in esoteric testing," one lab director said. "That's why LabCorp acquired **Genzyme**, **Monogram**, and other highly-specialized labs. Those labs offer primarily esoteric tests that LabCorp can have its sales reps upsell to office-based physicians.

"Specialty testing for cancer is a huge business opportunity for labs today," he continued. "That is equally true for cardiac marker tests, endocrinology tests, and similar tests for diabetes and other chronic diseases.

"The idea is to have doctors order those reference and esoteric tests and then persuade the health plan that physicians need these test results in order to identify chronic and costly conditions in patients early," added the lab director. "The argument is that use of expensive lab tests in this manner helps health plans control costs over time.

More Expensive Tests

"One example of how this specialty esoteric testing is changing the nature of the market is cholesterol testing," he stated. "At the most successful labs today, about 25% of the volume of cholesterol testing is now in the form of esoteric tests. Labs want to convince health plans that these expensive tests are needed as part of patients' annual physicals."

LabCorp is likely already pushing these types of esoteric tests to IBC's physicians in Southeastern Pennsylvania, sources said. "When labs push new esoteric tests, they tell physicians that they need to keep up with new technology. They say that any lab still offering routine testing when a more sophisticated esoteric test is available is not keeping pace with changes in the development of specialized testing," a source told THE DARK REPORT.

In an effort to control costs, some health plans keep the most common esoteric tests on the regular fee schedule and don't let labs carve them out. Health plans are doing this for some cardiac tests, prenatal assays, and certain tests for women's health, sources said.

Notable People

Emmanuel Farber Dead at 95, First to Describe Carcinogenesis

Pathologist's research led to 1964 surgeon general's report on the dangers of smoking and tobacco use

ONE OF THE PATHOLOGY PROFESSION'S MOST RESPECTED cancer researchers died last month. On August 3, Emmanuel Farber, M.D., passed away. He was 95 years old.

Farber was noted for his work in furthering the understanding of chemical carcinogenesis. His studies in experimental pathology revealed that chemical carcinogens can bind to nucleic acids, which could then generate specific DNA adducts. This process can be the start of carcinogenesis.

Emmanuel Farber, M.D.
1918-2014

With further research, Farber proved his theory. He demonstrated that, by treating the liver with chemicals in a step-by-step process, cancer could be induced.

Because of this work, he served on the first Surgeon General's Advisory Committee on Smoking and Health during the years 1961 to 1964. In 1964, this committee played a key role in the issuance of the surgeon general's report that warned the public of the dangers of smoking and tobacco-related disease.

Born in Toronto, Canada, in 1918, Farber earned his medical degree from the **University of Toronto** in 1942. He later got a doctorate in chemistry at the **University of California at Berkeley**.

In a long career, he held positions, including chair of pathology, at such institutions as **Tulane University**, **University of Pittsburgh School of Medicine**, and the **Fels Research Institute of Temple University**. In 1975, he returned to the University of Toronto to serve as Professor and Chairman of the Department of Pathology.

The list of medical associations, scientific societies, and advisory councils to which he belonged and often chaired is lengthy. In this country, it included the **National Institutes of Health** and the **National Academy of Sciences**.

It is worth noting that Emmanuel Farber, M.D., was not associated with the **Dana-Farber Cancer Institute** of Boston, Massachusetts. That institution was founded in 1947 by Sidney Farber, M.D., a pediatric pathologist who was not related.

Emmanuel Farber emphasized carcinogenesis must be understood in the context of the cellular, metabolic, molecular, and genetic changes that occur during the process.

Many honors came to Farber, such as the Rous-Whipple Award of the **American Society for Investigative Pathology** (ASIP) in 1982. He received the **Parke-Davis** Award in Experimental Pathology and the Samuel R. Noble Foundation Award. Then, in 1984, Farber was made a fellow of the **Royal Society of Canada**. The next year, in 1985, he was elected as an honorary member of the **Society of Toxicologic Pathologists**. TDR

Decision Support Update

UnitedHealthcare, BeaconLBS Respond with Statements

IN FLORIDA, BOTH CLINICAL LABS and physicians have expressed concerns about **UnitedHealthcare's** Laboratory Benefit Management Program that formally becomes effective on October 1. From that date forward, physicians will be required to obtain advance notification or pre-authorization for 81 tests.

Following our request for comment from UnitedHealthcare, **BeaconLBS**, and **Laboratory Corporation of America** (owner of BeaconLBS), THE DARK REPORT was asked to submit questions in writing. Upon receipt of those questions, statements were provided by **UnitedHealthcare of Florida** and BeaconLBS. Each statement is presented in full on this page and the following page.

Information about the Laboratory Benefit Management Program is available on the UnitedHealthcare website. There are documents that describe the process of advance notification which is described as follows:

> *Advance notification is required for Decision Support Tests rendered in the office (place of service 11) or clinical laboratory (place of service 81). If advance notification is not confirmed for Decision Support Tests, the test will not be eligible for payment. [Underline by TDR.]*

From UnitedHealthcare of Florida

Provided by a company spokesperson:

Below, are some additional facts to help you better understand our pilot [of the Laboratory Benefit Management Program] and its goals:

- UnitedHealthcare has a national clinical laboratory agreement with Labcorp.
- The lab program does NOT require prior authorization on tests ordered with the exception of the BRCA, which is a genetic test for breast cancer. However, it does request advance notification for several other tests. It is important to note that the advance notification process is NOT a clinical coverage review. It helps us verify necessary benefits and share applicable evidence-based clinical guidelines with the treating physician.
- UHC network laboratories are not required to participate in the BeaconLBS Laboratory of Choice network. However, network laboratories are required to comply with UHC Administrative Protocols and Clinical Policies. So, registration is required to ensure that the laboratory can meet those program requirements and minimize claims impact.
- To become a Laboratory of Choice, the lab does not need to pay a fee. However, the lab must meet (or negotiate) the terms of the BeaconLBS agreement, which include efficiency and quality criteria. For additional information, please visit: *https://www.unitedhealthcareonline.com/b2c/CmaAction.do?channelId=9cc7b96891e22410VgnVCM2000002a4ab10a____ (or http://tinyurl.com/p633fm8)*

This protocol is a notification requirement, not a precertification, prior authorization, or medical necessity determination. The participating physician (ordering provider) must notify UnitedHealthcare using Physician Decision Support prior to ordering the service.

The rendering laboratory will receive advance notification confirmation in the Outcome Summary or at BeaconLBS.com. The Outcome Summary is a printable onscreen message that includes test ordering results...

Of interest to pathologists and lab managers is the requirement that, when the physician is ordering tests covered by UnitedHealth's decision support requirement to obtain advance notification, two elements must be validated, as noted on the UnitedHealthcare website. First, the ordering provider must complete an electronic "question and answer (Q&A) through Physician Decision Support." Second, the rendering provider must meet the requirements of "CAP accreditation, sub-specialty certification, and/or secondary pathology review" as mandated by the program.

No Balance Bill To Members

In another section on the website, UnitedHealthcare writes that, for the rendering laboratory, "If there is no advance notification on file and the services are performed in place of service (POS) 11 or 81, the claim will deny as provider liability. Network providers cannot balance bill the member for covered services."

As these extracts from the information available on the UnitedHealthcare website indicate, the Laboratory Benefit Management Program has much complexity for physicians at the time they want to order tests and for each laboratory provider listed as a "Laboratory of Choice" for this program. TDR

From BeaconLBS

Provided by a company spokesperson:

Beacon Laboratory Benefit Solutions (BeaconLBS) identifies for physicians and their patients, high-quality, accredited laboratories and uses evidence-based clinical guidelines to improve quality and appropriate utilization of laboratory services. By making it easier to share information between physicians, labs, and health plans, BeaconLBS is helping lower the cost of care while improving the coordination and quality of a patient's laboratory services.

Lab testing is critical to patient care. As medical technology advances and becomes more complex, physicians are looking for education and support when ordering certain tests—particularly esoteric and genetic tests—and in efficiently identifying in-network labs for their patients' testing. Health plans are seeking better and easier ways to support patient care and physician choice while managing lab utilization and costs.

BeaconLBS is a laboratory benefit solutions company that connects physicians, payers and labs. It includes an online physician decision support and test ordering system that helps physicians choose the right tests, select labs that meet quality and efficiency criteria, and lower out-of-pocket costs for patients by meeting health plans' coverage requirements.

BeaconLBS will not direct the referral of specimens to labs. Physicians will select the referral lab for testing they order as they do today. The network will include independent labs, hospital labs, and pathology labs that meet the established quality and efficiency criteria.

Florida Doctor Questions Lab Test Pre-notification

United Healthcare's lab order system could slow down office workflow, says physician

CEO SUMMARY: An interesting tug-of-war may develop in Florida between a major health insurer and physicians. UnitedHealthcare will require physicians to obtain a pre-notification number for 81 lab tests by using the BeaconLBS system (developed by a subsidiary of LabCorp). One family practice physician is speaking out about his concerns that the new UHC requirement is "onerous" and will cause significant "work flow interruptions for office-based physicians."

PHYSICIANS IN FLORIDA are just learning about a new decision support system for clinical laboratory tests that goes into effect this month.

The Laboratory Benefit Management Program created by **UnitedHealthcare** will launch on October 1 in Florida for fully-insured commercial beneficiaries. It is operated by **BeaconLBS**, a business division of **Laboratory Corporation of America**. The health insurer is requiring physicians to use the system for pre-notification or preauthorization of approximately 81 clinical lab tests. *(See TDR, July 21, 2014.)*

For clinical labs and pathology groups serving UHC patients in Florida, the implementation of the BeaconLBS pre-notification program has been a most unwelcome development. Only about 18 lab companies (five owned by LabCorp) signed up to participate.

But little has been heard from the physicians who will be required to use the BeaconLBS system for pre-notification for the designated laboratory tests. This pre-notification number must appear on the laboratory requisition form for the laboratory that performs these tests to be paid by UHC. Both the **Florida Medical Association** and the **Florida Academy of Family Physicians** have asked their members for comments about their experience when they begin using the BeaconLBS system for their UHC patients.

One Florida physician said that the new system will be challenging, frustrating, and time-consuming. He also pointed out that this time-consuming requirement comes with no additional revenue and there is no proof that it will improve patient care.

Most Doctors Unaware

"The requirements of this system are onerous and the work flow interruptions for office-based physicians will be substantial," observed Dennis Saver, M.D., a family physician and geriatrician and founder of **Primary Care of the Treasure Coast**, in Vero Beach, Florida. "There are few better examples of an unfunded mandate than this Beacon system," added Saver, an adjunct clinical associate profes-

sor at the **University of Florida School of Medicine** and a clinical associate professor at the **Florida State University College of Medicine**.

While the FMA and FAFP have asked for physician comments, most doctors are unaware that the BeaconLBS system will change workflow, Saver said. "I have not heard much yet, perhaps because most docs have no clue what will befall them on October 1," he added.

Saver said his three most significant concerns are these:

1) The BeaconLBS system will be time-consuming for physicians who must use it.
2) UHC has proposed no increase in pay to physicians for this additional work.
3) The BeaconLBS decision support system is not, at this time, integrated with many of the electronic health record (EHR) systems physicians use. This means physicians may need to enter lab test orders twice.

"It will be time-consuming, complicated, and frustrating—all for no change in pay!" noted Saver. "A lot more work for the same pay constitutes a decrease in the pay rate. Period.

Is It A Contract Change?

"And UnitedHealthcare has presented this unilateral move as a policy change; but I consider it to be a contract change," he continued. "Unfortunately, UnitedHealth has a reputation for using their large market presence to dictate contract terms, which they are doing here."

Saver had his office staff review the procedures to obtain lab test pre-notification from the BeaconLBS system. The staff determined that a single test order will require five to seven extra minutes. Staff also estimated that between 20 and 30 mouse clicks and multiple computer screen changes will be needed to enter the information for each patient requiring lab testing through the BeaconLBS portal.

Compounding the problem is the fact that BeaconLBS is integrated with only a few EHRs. THE DARK REPORT spoke with a director at one of the nation's largest companies providing revenue and payment cycle solutions and connectivity services for providers. It supports a portal integrated with many EHR systems that enables electronic lab test ordering and resulting.

Double Order Entry For Tests

He confirmed that his company has integrated its software with the BeaconLBS system, meaning client physicians can use their EHR systems normally, without double entry. However, he noted that physicians who are not clients of his company will find the BeaconLBS system requires them to enter clinical lab orders twice: once for BeaconLBS and once in their EHR. "Physicians using that method for ordering lab tests and getting a pre-notification number will do twice the work," he said.

UHC has said BeaconLBS is working to integrate its decision support system with all EHRs. But this expert does not expect Beacon to have all EHRs integrated for the soft launch of the program September 2 or the official launch on October 1.

Physicians whose EHRs are not integrated with the BeaconLBS program will need to leave their EHRs to then open the BeaconLBS program, find the patient's name, and follow the steps to order the required tests. That begins the process of providing the additional information to complete the physician decision support for the tests, a process that Saver's staff estimates will take in total five to seven minutes.

For his part, Saver further pointed that, "because the BeaconLBS system is designed to ensure compliance with clinical guidelines for laboratory testing, it will no longer be possible for physicians to hand off lab test ordering to a nurse or medical assistant, as is common in most offices.

Florida Physician Asks: Why Is Decision Support Required for Some Tests the CDC Recommends?

IF THE FEDERAL CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) recommends a certain clinical laboratory test, why is that test required to go through decision support? That's a question Dennis Saver, M.D., founding president of Primary Care of the Treasure Coast, in Vero Beach, Florida, wants answered.

The 12-physician practice already has a moderately complex in-office lab and so the physicians understand lab testing, he said.

"We have negotiated to perform certain tests in-house," noted Saver. "For all other laboratory tests for UnitedHealthcare members, we are required to refer to Laboratory Corporation of America. In our circumstance, we might not have an option except to send orders to LabCorp, even if one of our physicians wanted to refer a specific patient's specimen to another laboratory."

In cases where evidence-based medicine guidelines are established for specific clinical lab tests, Saver questions the need to have such test orders go through the new BeaconLBS decision support system.

"As I understand it, each time a patient needs a Pap smear, that test request must go through the new BeaconLBS decision support system," stated Saver. "When you look at the list of tests that require decision support, every Pap smear has to go through it and every test for *Chlamydia* and *Gonorrhea*. This despite accepted clinical guidelines and the fact that these screening tests are required for HEDIS reporting.

"Plus, the Centers for Disease Control and Prevention has recommended that all baby boomers be screened for hepatitis C, yet the hep C screens are on the preauthorization list," he continued.

"The CDC guidelines also say every adult should be screened for HIV and that lab test is on the preauthorization list," observed Saver. "If these tests are recommended by expert organizations, why is decision support required before physicians can order such tests?"

Perhaps a bigger concern, noted Saver, is how quickly the number of tests designated for decision support may be increased by UnitedHealthcare. "In this proposal, these 81 tests are the first volley," he stated. "When does the second shoe drop and the third and the fourth, and we end up needing to obtain preauthorization for hundreds of lab tests? If physicians find this system onerous at inception, how much more intrusive and time-consuming will it be down the road?"

"This is not something the physician can delegate," he explained. "Given that the BeaconLBS system will require extra time to open the portal, find the patient, and follow all of the steps to accomplish the decision support, there should be a proportional increase in visit pay [to the physician] because there is going to be an increase in time for those patients who need lab testing."

Most primary care physicians schedule patients every 10 to 15 minutes, making five to seven extra minutes a substantial increase in visit time. To date, Saver said UHC has not answered his question about whether it will pay physicians for this additional time.

Physician Compensation?

"I have been on two different calls with UnitedHealthcare under two different circumstances," he commented. "Each time, I asked if physicians would be compensated, and each time the response was silence. They did not respond."

THE DARK REPORT asked BeaconLBS and UHC about compensating physicians for the additional time. As of press time, neither company had answered this question. The two companies were also asked

to provide information about how many EHR systems were compatible with the BeaconLBS system and no answer was provided.

UnitedHealthcare of Florida and BeaconLBS did each provide a statement in response to a list of questions submitted by THE DARK REPORT. Those statements are reproduced in their entirety on pages 11-12.

Statement By UnitedHealth

A spokesperson for UnitedHealthcare addressed the question of EHR compatibility, saying, "If you use a laboratory ordering system or EHR application that's already integrated with [Beacon's] physician decision support [system], a practice's workflow will not need to change. The application will automatically identify members who are part of the laboratory benefit management program and lead the provider's staff through the process for advance notification or prior authorization for decision support tests. If the practice is not using an integrated laboratory ordering system, it can use the standalone application at BeaconLBS.com to order decision support tests for members who are part of the laboratory benefit management program."

Saver was careful to point out that not all patients require lab testing. "However, for those who do, the increase in visit time is a concern," he noted.

Another factor is the mix of patients a physician sees, which can drive the number of lab tests ordered. "I see mostly geriatric patients; however, if I were in a younger market and 40% of my patients were with UnitedHealthcare, I believe this would slow me to a halt," observed Saver. "Typically in a younger population, about 25% to 30% of patients may need some lab testing and the thing that I do not know is what percentage of patients will need one or more of the 81 tests on the Beacon list.

"That percentage could be greater and it will require some time for a physician using the stand-alone portal to learn and remember which lab tests are on the BeaconLBS pre-notification list," he said. "That means the learning curve will be steep and there is no evidence that this effort does anything to improve patient care.

"As a contracted physician for UnitedHealthcare, I find this whole idea that we need to do more work for no additional pay to be extraordinarily objectionable!" declared Saver. "And, frankly, I find UnitedHealthcare's argument that this will create better medicine to be unsupported. This simply means that UnitedHealth will pay less in lab fees."

Saver identified another problem that is likely to occur each time a physician does not go through the BeaconLBS system for a listed test. "That test becomes a noncovered service and that means patients will be billed for those tests," he noted. "That alone will create a huge uproar. The patients will not understand that it is UnitedHealthcare's decision to deny the test.

Patients May Blame Docs

"Instead, they'll think it's the doctor's fault for not filling out the papers correctly to get the test covered," predicted Saver. "Furthermore, each time a patient needs to use an outside lab for testing, the physician will have to print off the decision support information and give it to the patient to make sure that the tests are covered. Then, if the patient doesn't pay the lab at time of service for a test on the list which has not gone through the physician decision support system, the lab will need to pursue the patient to collect its payment."

Dr. Saver's questions and observations raise valid points about UnitedHealthcare's Laboratory Benefit Management Program. In today's era of patient-centered care, will the patient be better served by this complicated arrangement? TDR

—Joseph Burns

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Longer Pay Cycle for Labs, Plus Lower Collection Rate

One major reason is the increasing number of patients enrolled in high-deductible health plans

CEO SUMMARY: Across the United States, clinical labs, histology labs, and pathology groups are experiencing both a much longer payment cycle for claims and a decreased gross collection rate. Blame can be placed on several trends. One trend is the steady increase in the number of patients with high-deductible health plans. Another trend involves payers implementing detrimental changes to their out-of-network payment policies. Collectively, these facts are making it tougher for labs to get paid.

IT IS A FACT THAT DURING 2014, collecting money is tougher for histology labs, clinical labs, and pathology groups. Labs are not only experiencing a longer payment cycle for their claims, but their gross collection rates for these claims is decreasing.

These two trends were confirmed by executives at **McKesson Corporation's** Business Performance Services unit. It provides services in practice management, billing, and collection to more than 374 laboratories and pathology group practices throughout the United States.

Multiple factors are responsible for slower payment and the reduced gross collection rate that many labs and pathology group practices experience. One trend is the substantial increase in the number of patients enrolled in high-deductible health plans (HDHPs).

A related, but distinct trend, is that more health insurance plans require patients to be responsible for a larger portion of the total payment. Consequently, laboratories now spend much more time and resources to collect money directly from patients.

"Clinical labs and pathology groups are receiving lower reimbursement plus they are being paid more slowly than in years past because of the aforementioned factors," explained Eddie Miller, Vice President of Pathology Operations for McKesson Business Performance Services.

Larger Patient Deductibles

"Clinical labs and pathology groups are seeing the effects of these increased deductibles," noted Miller. "In some cases, patients are responsible for as much as half of the allowed amount for services rendered," he noted. "Also, when trying to pay their healthcare bills, it appears that many patients with these higher deductibles are struggling or finding themselves with limited resources.

"Under the exchange plans, there is a range of what the insurers will pay and what individuals will pay," he stated. "The ACA-mandated exchanges offer Bronze, Silver, Gold, and Platinum health plans. Under the best plans, insurers pay 90% of the costs and individuals or families will pay 10%.

"Other exchange plans within the mandated ranges are set at an 80/20 split, 70/30 split, or 60/40 split," said Miller. "Another alarming trend we see with some commercial payers is the offering of plan products that have a 50/50 split.

"Higher patient responsibility means that medical providers will have to go through multiple billing cycles to collect larger amounts of dollars from patients," he said. "Currently, more patients are opting for HDHP plans that have lower premiums without possibly understanding the impact that the higher co-insurance percentage (30% or 40% or more) will have. When these high deductibles are not met, then the total allowable amount will shift to the patient.

"The irony is that patients are selecting plans that have the lowest premiums. But those health plans require the highest deductibles" observed Miller. "Patients with such plans are responsible for their deductibles first before the insurer covers the patient's medical costs."

Kaiser Health News reported that, during 2014, the maximum out-of-pocket that consumers will pay this year for most plans will be $6,350 for an individual and $12,700 for a family.

Out-Of-Network Pay Changes

Miller identified another trend that is causing slower claims settlement and decreased gross collections for labs throughout the nation. "Most carriers are now changing their reimbursement for out-of-network providers," he noted. "Historically, out-of-network providers could expect to receive a higher rate than in-network providers that would typically be an allowable of up to 100% of the billed charge. Today, we see a trend of carriers reducing their out-of-network benefits to zero.

"All of these factors have the inevitable effect of reducing payments and requiring labs and all healthcare providers to chase patients for a larger percentage of their revenue," concluded Miller. "In turn, this mandates that revenue cycle managers modify their processes to accommodate the renewed focus on patient collections." TDR

—Joseph Burns

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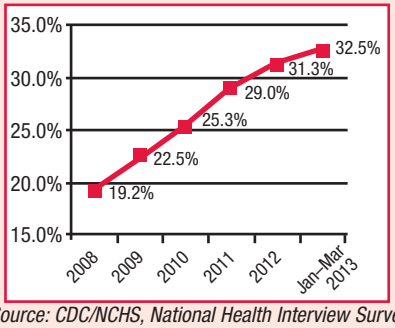
High-Deductible Health Plan Enrollment 2008-2013

Percentage of individuals under 65 with private health insurance and enrolled in an HDHP



Source: CDC/NCHS, National Health Interview Survey

EARLIER THIS YEAR, the AFLAC Workforces Report was released. According to **BenefitsPro.com**, responses were gathered from 1,856 benefits decision-makers and 5,209 employees. Of companies surveyed, 56% increased copayments and/or shares of premium between 2013 and 2014.

Of interest to lab executives was the survey findings about the ability of individuals to pay these high deductibles. As reported by BenefitsPro.com, the findings explain why labs are having a tough time collecting high deductibles from patients:

- 53% would use a credit card and/or borrow from their 401(k)s to cover the costs;
- 49% have less than $1,000 on hand to cover out-of-pocket expenses associated with a serious illness or accident;
- 27% have less than $500 on hand to cover those costs;
- 42% say they're not prepared at all or are not very prepared to pay such out-of-pocket expenses;
- 13% have been contacted by a collection agency about outstanding medical bills.

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

There will be one less vendor of laboratory information systems (LIS) when a major acquisition is completed. Last month, **Siemens AG** announced that it would sell **Siemens Health Services** to **Cerner Corp.** for a price of $1.3 billion. Analysts believe that Cerner was motivated to do the deal because, among other benefits, it would gain inside access to sell its EHR solution to customers of SHS. The sale is expected to close in the first quarter of 2015. SHS uses the brand name of "Soarian" for its LIS and other software systems.

MORE ON: *Siemens*

Also in August, Siemens agreed to sell the clinical microbiology business of **Siemens Diagnostics** to **Beckman Coulter Corporation**, a subsidiary of **Danaher Corporation**. No sales price was disclosed and the sale is expected to close in the first quarter of 2015. Analysts noted that, under Siemens, this business unit has more than 6,000 Microscan microbiology instruments placed globally. With this product line, Beckman Coulter will be in a better position to be a sole source vendor to clinical laboratories.

FDA PREPARES TO REGULATE LDTS

By now, most pathologists and lab managers know that the **Food & Drug Administration** gave the legally-required 60-day notice to Congress on July 31 that it intended to regulate laboratory-developed tests (LDTs). The FDA's draft guidance it provided to Congress provides useful insights on what labs with LDTs will need to do to gain FDA clearance for their LDTS. On September 17, THE DARK REPORT will conduct the webinar "FDA Prepares to Regulate LDTs: What You Must Know, What Your Lab May Need to Do."

ADD TO: *LDTs*

Speaking at the webinar on FDA regulation of LDTs will be Jane Pine Wood and Richard Cooper, attorneys with **McDonald Hopkins**; and Kuo Tong, CEO of **Quorum Consulting** of San Francisco. All three have experience working with the FDA to obtain clearance for medical devices, *in vitro* diagnostic tests, and specialty LDTs. Among other recommendations, they advise labs with LDTs that it would be timely to gather clinical data now in order to be ready to beat the rush of labs expected to file applications with the FDA once the LDT regulations are finalized and take effect at a date in the near future. Webinar details can be accessed at *www.darkdaily.com.*

DARK Daily
Clinical Laboratory and Pathology News/Trends

DARK DAILY UPDATE

Have you caught the latest e-briefings from DARK Daily? If so, then you'd know about...

...the top 10 rankings of EHR market share in the hospital and ambulatory markets. **Epic** is number one on both lists. Just 10 EHR products control 90% of the hospital market, while the top 10 EHRs in the ambulatory market hold a market share of only 65%.

You can get the free DARK Daily e-briefings by signing up at www.darkdaily.com.

That's all the insider intelligence for this report. Look for the next briefing on Monday, September 22, 2014.