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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

Aetna, Anthem to Pay Pathology Groups Less

TWO OF THE NATION'S LARGER HEALTH INSURERS—**AETNA** AND **ANTHEM**—ARE CUTTING WHAT THEY PAY for the professional component of certain clinical and anatomic pathology codes.

In its communications with pathology groups about this policy change, Aetna says it will no longer pay for most clinical laboratory claims submitted with the modifier 26 for professional component services. It says this step is to align current practices with its longstanding policy of not paying a professional component for clinical pathology professional services. Some national pathology billing experts believe there are certain pathology groups that stand to lose as much as $300,000 per year in revenue from this change. *(See pages 8-9.)*

By contrast, Anthem's actions are more troubling for the pathology profession as a whole. As you will read on pages 3-7, state-by-state, Anthem is pushing two major changes onto anatomic pathology groups. One change is to terminate the pathology group's professional services contract and move the group to a laboratory contract, handled by the insurer's ancillary services contracting department.

The other change is to reduce what it pays for nearly all the anatomic pathology CPT codes by amounts reported to be 50% to 70% less than what it currently pays. Anthem gives pathology groups a limited number of days to accept or reject its offer. There are reports that—after certain pathology groups chose to reject the offer and go out of network—representatives from Anthem went to the hospitals and health networks served by these pathology groups to inform them that their anatomic pathology provider had opted to cancel its Anthem contract and go out of network.

It is easy to simply categorize the actions of Aetna and Anthem to cut prices for pathology services as their response to the PAMA-related cuts to Medicare Part B lab test fees. After all, across the nation, reports are pouring in about how state Medicaid programs and private health insurers are following Medicare's lead and cutting what they pay laboratories.

However, deeper changes are happening among the larger private health insurers. These current actions should be seen in context of how other insurers are instituting prior-authorization requirements, narrowing provider networks, and refusing to cover many new lab tests. **TDR**

Anthem Rolling Out More Anatomic Path Price Cuts

Insurer is also moving pathology groups from professional contracts to ancillary service contracts

CEO SUMMARY: Anthem is making big changes to its relationships with anatomic pathology groups. Getting most of the attention at the moment are the insurer's letters announcing price cuts for anatomic pathology services of 50% to 70% of Medicare fees. But another major change may also trigger negative consequences for pathologists. Anthem is moving pathology contracts out of its professional services unit and over to its ancillary services unit, which typically contracts with clinical labs.

In recent weeks, anatomic pathology groups in a growing number of states received notices from **Anthem**, one of the nation's largest insurers with 40.5 million beneficiaries. The notices announce major changes in the way Anthem contracts for anatomic pathology services.

Anthem's first change is to cut the prices it pays for most anatomic pathology (AP) services by 50% to 70% of 2018 Medicare fees. These fee cuts will get the most attention by pathology groups and their practice advisors.

But it is the other substantial change that Anthem is pushing on pathology groups that has the potential for serious negative consequences over the long term. That change is to move the contracts it has with pathology groups from the Anthem's professional services division to its ancillary services division.

Effectively, Anthem will now treat physicians who are board-certified in pathology in the same way that it treats clinical laboratories and other ancillary providers. This change has interesting consequences, one of which is how pathologists will be accredited with the health insurer going forward.

Anthem's latest effort to cut what it pays for anatomic pathology services started last fall. In November, Anthem made significant cuts in payment rates for the professional component (PC) for lab services in Missouri, according to **Vachette Pathology**, a consulting firm in Sylvania, Ohio. At the time, Anthem slashed what it pays for the PC portion of certain tests in the 80000 series of CPT costs by as much as 70%, Vachette said.

Reporting on Anthem's rate cuts to various anatomic pathology services, **APS**

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R. Lewis Dark, Founder & Publisher. Robert L. Michel, Editor.

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Medical Billing, in Toledo, Ohio, said in a letter to its clients that the rate changes Anthem was making vary widely by state and affect both the professional component and technical component.

Last month, the **American Academy of Dermatology Association** (AADA) sent a letter to Anthem, expressing serious objections to the price cuts. Writing on behalf of the more than 14,000 association members, AADA President George Hruza, MD, MBA, said the cuts will result in reductions in Anthem's payment for lab services of 50% to 70%. Hruza based this estimate on a notice of a change in a contract that dermatopathologists in Ohio received on April 17.

"It is the AADA's understanding that this material change in contract will reduce reimbursement for most office-based pathology lab services to 50% of 2018 Medicare rates, with 86 pathology tests being reduced to 70% of 2018 Medicare rates," Hruza wrote. "In addition to the announced contract modification in Ohio, it is understood that similar reductions in dermatopathology reimbursement may be implemented in other Anthem states."

A Rate Realignment?

In correspondence with Anthem, pathologists have learned that the insurer calls the payment cuts it is making to AP services, a "rate realignment."

Anthem said it wants its payments to be site-neutral—meaning payment will be the same regardless of whether the service is delivered in a hospital-based lab or an independent lab. The insurer's aim is "to align compensation for lab rates in all settings so that its members would pay the same in out-of-pocket costs regardless of the site of service," pathologists said.

"These steep cuts in the professional component for pathology services are a significant concern because they are unsustainable regardless of whether they affect hospital-based services or independent-lab services," commented Vachette's Vice President of Client Services Ann Lambrix.

"As the second-largest health insurance company with 40.5 million beneficiaries, Anthem had previously been among the best-paying insurers," added Lambrix.

"Hospital-based labs may struggle more because hospital labs typically serve patients who are seriously ill and often have multiple conditions," she explained. "That is why testing for hospital patients is more complex and comes with higher costs. Payers recognize that fact and have generally reimbursed hospital labs at higher rates for that reason."

However, Anthem's deep price cuts ignore this reality. It is why THE DARK REPORT believes that a growing number of pathology groups are sending termination notices to Anthem. These groups recognize that Anthem's price cuts—coming on top of Medicare price cuts—will erode the financial stability required for groups to sustain accurate, high-quality services.

Anthem's Price Cuts

After introducing the lower rates for the professional component in Missouri last fall, Anthem next introduced lower prices on Jan. 1 in Alaska and Washington. Based on letters sent to its pathology group clients, Vachette said Anthem is scheduled to cut AP rates as follows:

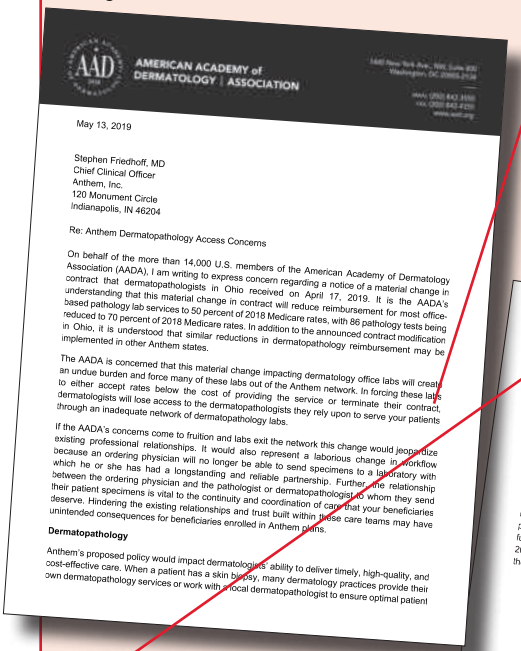
- **July 1:** California, Georgia, and Indiana.
- **July 10:** Ohio.
- **Aug. 1:** Wisconsin.
- **Sept. 1:** Kentucky, Virginia and West Virginia.
- **Jan. 1, 2020:** New York.
- **No date yet:** New Hampshire.

"Providers in Kentucky, Colorado, Connecticut, Maine, and Nevada are expected to experience similar cuts in the near future," Lambrix added.

In a note on its website, Vachette explained that many of the new rates reflect a roughly 70% drop from previously-

American Academy of Dermatology Sends Letter of Objection on Price Cuts to Anthem

IN ITS MAY 13, 2019 LETTER TO ANTHEM, the president of the American Academy of Dermatology Association (AADA) voiced serious concerns about the deep price cuts the health insurer was implementing to many anatomic pathology CPT codes. AADA President George Hruza, MD, MBA, FAAD, asked Anthem to establish a dialogue with AADA to work through these concerns. Relevant sections of the AADA letter are highlighted below.



AMERICAN ACADEMY of DERMATOLOGY | ASSOCIATION

May 13, 2019

Stephen Friedhoff, MD
Chief Clinical Officer
Anthem, Inc.
120 Monument Circle
Indianapolis, IN 46204

Re: Anthem Dermatopathology Access Concerns

On behalf of the more than 14,000 U.S. members of the American Academy of Dermatology Association (AADA), I am writing to express concern regarding a notice of a material change in contract that dermatopathologists in Ohio received on April 17, 2019. It is the AADA's understanding that this material change in contract will reduce reimbursement for most office-based pathology lab services to 50 percent of 2018 Medicare rates, with 86 pathology tests being reduced to 70 percent of 2018 Medicare rates. In addition to the announced contract modification in Ohio, it is understood that similar reductions in dermatopathology reimbursement may be implemented in other Anthem states.

The AADA is concerned that this material change impacting dermatology office labs will create an undue burden and force many of these labs out of the Anthem network. In forcing these labs to either accept rates below the cost of providing the service or terminate their contract, dermatologists will lose access to the dermatopathologists they rely upon to serve your patients through an inadequate network of dermatopathology labs.

If the AADA's concerns come to fruition and labs exit the network this change would jeopardize existing professional relationships. It would also represent a laborious change in workflow because an ordering physician will no longer be able to send specimens to a laboratory with which he or she has had a longstanding and reliable partnership. Further, the relationship between the ordering physician and the pathologist or dermatopathologist to whom they send their patient specimens is vital to the continuity and coordination of care that your beneficiaries deserve. Hindering the existing relationships and trust built within these care teams may have unintended consequences for beneficiaries enrolled in Anthem plans.

Dermatopathology

Anthem's proposed policy would impact dermatologists' ability to deliver timely, high-quality, and cost-effective care. When a patient has a skin biopsy, many dermatology practices provide their own dermatopathology services or work with a local dermatopathologist to ensure optimal patient

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...matopathology that one must pass in order to receive ABD's certification in dermatology. There are harmful consequences to ignoring the quality and reliable diagnosis dermatopathologists can provide. Denying full access to payer networks to qualified dermatology practices, dermatopathologists, and dermatopathology laboratories will result in delays in diagnosis, incorrect work-ups, unnecessary imaging, and patient harm when erroneous diagnoses are made. The medicolegal liability risk is also substantial when analysis of biopsy tissue is substandard in quality.

In summary, the AADA is extremely concerned regarding the impact the material change in contract will have on office-based laboratories and their ability to participate in your network. The downstream impact of this policy could result in a lack of choice in dermatopathology. Dermatologists are nearly unanimous in their belief that their "right to read one's own slides" and/or to refer to a dermatopathology "consultant of choice" should be preserved.

The AADA supports preserving these choices and welcomes the opportunity to establish a dialogue so we can provide you with the dermatologist and dermatopathologist experience and perspective on this critical, but often misunderstood issue. We welcome the opportunity for further dialogue. Please contact David Brewster, Assistant Director for Practice Advocacy, at 202-609-6334 or dbrewster@aad.org to set up a mutually agreeable time to meet and discuss these issues.

Sincerely,

George Hruza, MD, MBA, FAAD

Valuation of Procedures

The American Medical Association (AMA) Relative Value Scale (RVS) Update Committee, commonly referred to as the RUC, is a transparent multispecialty committee that reviews and values the resources required to provide physician services. Through this review, the RUC evaluates physician time, direct expense, and the indirect expense incurred to deliver care, including diagnostic pathology services, and makes a recommendation to CMS. CMS makes any adjustments in value that it deems warranted and then converts them into RVU's which is the foundation of the Medicare Fee Schedule.

All codes receive extensive review to ensure the value is reflective of the effort and resources required to deliver the service. In 2012 CPT 88305 (Level IV-Surgical pathology and microscopic examination), the most common code in dermatology, underwent this review and the value decreased by 33%. With a robust process in place to determine the value of a service, any reduction in reimbursement for pathology services below the Medicare Fee Schedule [by Anthem] is not warranted given the validity of the current CMS value.

The AADA is also concerned that the steep reduction in reimbursement, without justification, could be considered a violation of the good faith and fair dealing covenants requirements in these contracts [with Anthem].

Anthem Responds to Contract Questions

IN RESPONSE TO A QUESTION from THE DARK REPORT, Anthem provided the following statement: "Anthem's goal is to help ensure our consumers have access to high quality, affordable healthcare, and one of the ways to help achieve that goal is to routinely analyze and rebalance professional fee schedules for medical services, including lab services.

"This evaluation includes competitive benchmarking, analysis of government reimbursement, consideration of changes in care delivery models, and the impact of rate changes on consumers. Anthem's adjustment to office-based lab fee schedules is an effort to address the wide disparity in prices for this service. Anthem has successfully worked to obtain competitive pricing with a robust network of providers and is committed to providing numerous lab testing access points for our consumers at rates that are consistent and clear," said the statement.

"Anthem followed the notice provisions defined in our provider agreements when making changes to the fee schedule. We won't comment on the specifics of Anthem's fee schedule, which is proprietary and confidential," said the insurer.

negotiated reimbursements for many groups and are a significant reduction from 2019 Medicare rates published in the Physician Fee Schedule and Clinical Laboratory Fee Schedule.

Anthem Plans in Ohio

In the same note, Vachette quoted from a letter Anthem sent to pathologists in Ohio. "The 80000 to 89999 CPT codes are involved, although certain in-office testing will be exempt from these changes," the letter said. "Rates for 0362T and 0373T will be reduced to be consistent with the recent changes to those code definitions that reduce the time per unit from 30 minutes to 15 minutes. The rate for 97153 will be reduced to reflect an update to the manner in which adaptive behavior services may be billed."

The new rates will differ from one state to another. "For example, in Kentucky 88300 to 88309 will not be impacted, possibly as a concession to those [pathologists] who have already pushed back against these changes in other states," Vachette said.

Pathology groups that disagree with these changes must send a Notice of Objection within 10 days of receiving Anthem's notice, Lambrix said. This short time to object is a source of contention.

APS Medical Billing encouraged its clients to object to the rate changes each time a lab or group gets a notice. "In many cases, groups have objected and sent notice of termination for the impacted plans," the biller said.

Lambrix agreed, saying some groups have said they will end their contracts rather than take drastic cuts in payment that do not cover their costs. She could not estimate how many labs and pathology groups would end their Anthem contracts.

Payment Cuts of 70%

"As a result of the changes, Anthem is instituting a decrease in payment of about 70% in the most extreme instances," she added. "At that point, I called Anthem and said, 'These numbers must be wrong,' but I was told they were correct," Lambrix explained. "At the same time, I was told that a lot of pathologists in Missouri had called to complain and that Anthem was reconsidering.

"One pathology group we work with in Ohio had a reduction from Anthem of roughly 42% of Medicare on all codes in the 80000 series except for 88305, which got a $7 increase," she explained.

In Missouri, pathologists were not much concerned when Anthem announced that new lower rates were coming, Lambrix said. "In November, the letters from Anthem indicated there would be changes to the fee schedule in

Anthem Ends 'Professional Provider' Agreements, Moves Pathology Groups to 'Ancillary Provider'

IN PAST MONTHS, Anthem sent anatomic pathology groups in several states letters that terminated their "professional provider agreements" with the insurer. In place of those agreements, Anthem enclosed a new "ancillary provider agreement" that it uses for clinical laboratory providers. This is an unprecedented action in the field of managed care contracting and has many implications for the pathology profession.

Reproduced below is one example of an Anthem letter sent to an anatomic pathology group in the Midwest. This letter terminates the group's existing professional provider agreement and offers the pathology group an ancillary provider agreement in its place.

Excerpts from Anthem letter to a Pathology Group:

Re: Notice of Material Amendment and Termination of Professional Provider Agreement

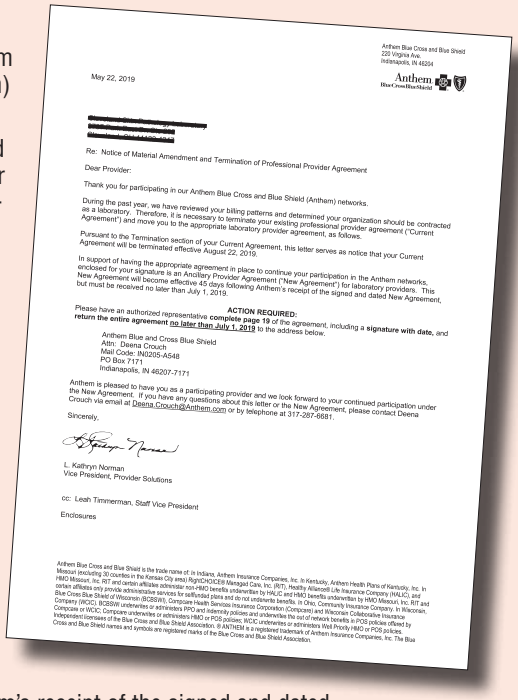
Dear Provider:

Thank you for participating in our Anthem Blue Cross and Blue Shield (Anthem) networks.

During the past year, we have reviewed your billing patterns and determined your organization should be contracted as a laboratory. Therefore, it is necessary to terminate your existing professional provider agreement ("Current Agreement") and move you to the appropriate laboratory provider agreement, as follows.

Pursuant to the Termination section of your Current Agreement, this letter serves as notice that your Current Agreement will be terminated effective August 22, 2019.

In support of having the appropriate agreement in place to continue your participation in the Anthem networks, enclosed for your signature is an Ancillary Provider Agreement ("New Agreement") for laboratory providers. This New Agreement will become effective 45 days following Anthem's receipt of the signed and dated New Agreement, but must be received no later than July 1, 2019.



Anthem Blue Cross and Blue Shield
220 Virginia Ave.
Indianapolis, IN 46204

Anthem Blue Cross Blue Shield

May 22, 2019

[redacted]

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ACTION REQUIRED:
return the entire agreement no later than July 1, 2019 to the address below:

Anthem Blue and Cross Blue Shield
Attn: Deena Crouch
Mail Code: IN0205-A548
PO Box 7171
Indianapolis, IN 46207-7171

Anthem is pleased to have you as a participating provider and we look forward to your continued participation under the New Agreement. If you have any questions about this letter or the New Agreement, please contact Deena Crouch via email at Deena.Crouch@Anthem.com or by telephone at 317-287-6881.

Sincerely,

L. Kathryn Norman
Vice President, Provider Solutions

cc: Leah Timmerman, Staff Vice President

Enclosures

Anthem Blue Cross and Blue Shield is the trade name of: in Indiana, Anthem Insurance Companies, Inc. In Kentucky, Anthem Health Plans of Kentucky, Inc. In Missouri (excluding 30 counties in the Kansas City area) RightCHOICE® Managed Care, Inc. (RIT), Healthy Alliance® Life Insurance Company (HALIC), and HMO Missouri, Inc. RIT and certain affiliates administer non-HMO benefits underwritten by HALIC and HMO benefits underwritten by HMO Missouri, Inc. RIT and Blue Cross Blue Shield of Wisconsin (BCBSWI). Compcare Health Services Insurance Corporation (Compcare) and Wisconsin Collaborative Insurance Company (WICIC). BCBSWI underwrites or administers PPO and indemnity policies and underwrites the out-of-network benefits in POS policies offered by Compcare or WICIC. Compcare underwrites or administers HMO or POS policies; WICIC underwrites or administers Well Priority HMO or POS policies. Independent licensees of the Blue Cross and Blue Shield Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

Missouri," she explained. "But the way the letters went out didn't raise any alarms until the pathologists there started getting paid at the lower rates and noticed that the fee schedules had changed significantly.

"Previously, pathologists in Missouri had been getting paid about $66 for the PC under the old rates, but under the new rates, the fee schedule calls for paying less than $15 for the professional component," she added. "That's a $50 cut in payment—a 78% decrease—for the PC portion of CPT 88305." **TDR**

—Joseph Burns

Contact Ann Lambrix at (517) 486-4262 or alambrix@vachettepathology.

Aetna Ends Payment for Professional Component

Insurer says it will stop out-of-network payments for pathology review of clinical laboratory tests

CEO SUMMARY: As of Aug. 1, Aetna will stop paying out-of-network pathologists for the professional component review of certain clinical pathology tests. Until now, the health insurer has paid for the professional component when out-of-network labs billed for clinical lab tests using the modifier 26. In a notice to labs, Aetna said it will pay only for the professional component for 106 AP codes. One pathology consulting firm says this change could cut some pathology groups' revenue by as much as $300,000 per year.

STARTING AUG. 1, **Aetna** will end payment for the professional component of clinical laboratory tests for out-of-network labs.

In a notice to clinical laboratories regarding its claims payment policies, the health insurer in Hartford, Conn., said it will allow the modifier 26 only for anatomic pathology procedures, said Alex Mitchell, Quality Programs Coordinator for **Vachette Pathology**, a revenue cycle management firm for clinical laboratories and anatomic pathology groups. Aetna and other insurers use the modifier 26 to distinguish the professional component of CPT codes involving both the professional and technical component.

"Up to this point, Aetna would pay for the professional component of clinical pathology for out-of-network groups or those groups that had fought to have that language included in their contracts," Mitchell said in an interview with THE DARK REPORT.

"Now, it appears that Aetna is seeking to close that revenue stream," he added. "In the letter it sent to labs, Aetna said it needed to make the change to address a systems issue that wasn't in line with its payment policies."

Aetna's letter to labs also mentioned that the insurer had recently audited its claims payment processes and found that it had paid some providers for claims that did not align with its "longstanding policy for modifier 26 when billed with laboratory services."

New Modifier 26 Policy

Now it is revising its claims-system edits so that on Aug. 1, the policy will be applied consistently. "We only allow modifier 26 for laboratory services (80000 CPT series) billed with one of the following codes."

As of this date, Aetna did not return THE DARK REPORT's request for comment.

Vachette Pathology President Michelle Matney explained that, in late June, Vachette and its client labs learned that Aetna was rewriting the payment policy regarding the use of modifier 26. "They've outlined the very specific CPT codes that will be recognized and paid, which is obviously a significant shift," she said.

While the shift is significant, it's difficult to estimate how much of an effect

the change will have on clinical labs. "We have one group that's going to lose about $1,000 to $2,000 in revenue each month, and that amount will add up over the year," Matney commented. "On the other end of the spectrum, we have a group that has Aetna as one of its major payers, and they stand to lose almost $300,000 annually from this change.

Aetna Is Big Payer in Texas

"That second group happens to be in Texas where the **Texas Society of Pathologists** is very strong," she added. "And the society in Texas is already working with Aetna to see if they can eliminate some of the loss that their member groups there will feel from this change. That's significant because Aetna is a big payer in Texas."

Estimating the effect of the change also is difficult because the policies regarding payment for the professional component for clinical pathology tests vary widely among the nation's health insurers, Matney explained. "**Cigna** pays for the professional component for clinical lab tests, for instance, but **UnitedHealthcare** does not. In fact, Cigna will negotiate a rate for out-of-network labs."

The change affects all CPT codes from 80000 to 87999 when the 26 modifier is applied, Matney explained. "Aetna will no longer pay for clinical lab tests with a 26 modifier regardless of whether the lab is in network or out of network," she said. "If a lab has a contract with Aetna that says the insurer will pay for testing using these codes and the 26 modifier, that contract language might not survive this change.

"If that language is in a pathology group's Aetna contract, the group might have to go back to the bargaining table to try to pick up some of the revenue that would be lost with this change," she added. "At the same time, the lab's anatomical codes will be paid because Aetna said very specifically in its letter that claims for the 106 AP codes with a 26 modifier will be recognized."

This change comes as Anthem also is making changes in the way it pays for clinical and anatomic pathology testing, Mitchell added. *(See "Anthem Rolling Out More Anatomic Path Price Cuts," pages 3-7.)*

"But unlike the Anthem issue, where the changes to the fee schedule vary by state, Aetna is making an across-the-board change and will no longer pay for these services effective in about four weeks," he said.

"The exact impact of eliminating payments for these services will vary depending on a group's overall Aetna volume and whether or not they were already precluded from billing for these services due to contract language," he added. "But this is just another example of a revenue stream being cut off as pathologists and labs continue to operate under the financial constraints implemented under PAMA." PAMA is the Protecting Access to Medicare Act of 2014.

Unclosed for Nearly 15 Years

"We should note that Aetna let this loophole remain unclosed for nearly 15 years," Matney commented. "Essentially, this change is the same one Aetna announced in about 2005 or 2006. I've done this work for many years and I remember when Aetna made a similar announcement then.

"At the time, Aetna sent out a letter saying it would not pay for these types of services and it would update their claims processing systems to reflect that change," she added. "Since then, this policy has not been enforced widely, and it seemed to go away for a while.

"But now the letter from Aetna clearly states that the issue resulted from a claims-processing system error and it is closing that door now by not paying for any of those codes," said Matney. TDR

—Joseph Burns

Contact Michelle Matney at 517-486-0389 or mmatney@vachettepathology.com; Alex Mitchell at amitchell@vachettepathology.com.

Four Insurers, Quest Developing Blockchain

➤Synaptic Health Alliance now using blockchain to improve accuracy of provider databases, directories

➤➤CEO SUMMARY: Organizations developing blockchain technology say it is a tamper-proof method of sharing data across networks and among providers, health insurers, and health systems. The Synaptic Health Alliance includes four of the largest health insurers, a health network, and Quest Diagnostics. Its first project, now in its second year, will use blockchain to create a common provider database that each collaborator can use to produce and keep provider directories up-to-date.

Blockchain is a new technology that promises significant benefits if it can be successfully adapted to commercial purposes in the clinical laboratory industry. In healthcare, a collaboration of health insurers, **Quest Diagnostics**, and others is exploring ways that blockchain can improve how provider data is collected, shared, and used.

Two years ago, health insurers **UnitedHealthcare**, **Humana**, **MultiPlan**, and **Optum**, and the clinical lab company Quest Diagnostics, agreed to form the **Synaptic Health Alliance** to assess the feasibility of using blockchain to share data on healthcare providers. Since then, **Aetna** and the health system **Ascension** have joined the alliance.

➤Time-Stamped, Tamper-Proof

Blockchain is a time-stamped and tamper-proof log of activity that labs, other healthcare providers, and health insurers can share across a network of computers. Any tamper-proof technology is attractive to clinical laboratories, health systems, and health insurers to transmit data quickly and securely and to help prevent the data breaches four of the nation's largest labs discovered earlier this year. *(See pages 13-16.)*

Synaptic Health Alliance's first effort is to find ways to use blockchain's data-collection technology to fix errors in provider directories and to cut the cost of keeping such data up to date.

"The Synaptic Health Alliance is a coalition of healthcare leaders who are collaborating to solve some of the industry's toughest problems around the emerging technology called blockchain," explained Brian LaPenna, Quest's Vice President of Software Engineering and Design.

"Our first project was announced in April 2018 when the alliance started to tackle some of the high costs of healthcare provider data management," he said. "We wanted to test the premise that administrative costs and data quality can be improved by sharing provider data among alliance members. We also wanted to know if changes the different parties made across the blockchain would facilitate the distribution of more accurate data."

Clinical labs and pathology groups know the challenges health insurers face

in keeping their provider directories up to date. Beneficiaries use these directories when choosing physicians, hospitals, and other healthcare providers.

Inaccurate directories can lead to surprise medical bills and other out-of-network charges for consumers who are confused when choosing providers from out-of-date directories. When consumers complain about such charges, state and federal legislators pass laws to prevent such problems.

"In this first pilot project involving a database of providers, we deployed a secure, decentralized, multi-cloud, and multi-enterprise blockchain network," explained LaPenna. "We found there were immediate benefits in identifying inactive locations and mismatched addresses in shared provider directories.

"That was the main focus of that initial pilot project," he noted "These findings showed that the alliance can do more work with provider directories in future phases of the project. In that way, we proved that we could have very good success using blockchain. Thus, the next step is to expand how it is used."

Labs Typically First to Know

A focus on provider locations is important because clinical laboratories and pathologists are usually the first to know when a doctor or other provider opens a new office or moves from one location to another.

When a doctor sees his or her first patients, a lab test order almost always results. Therefore, labs are well positioned to help health insurers solve the problem of inaccuracies in provider directories.

"When you think about what happens when physicians or other medical professionals change their addresses, they also may change what health system or health insurer they're affiliated with," said LaPenna. "That information requires an update in the provider networks.

"Because labs can see that information and share it with health insurers, we can ensure that updates to the provider database are being made," he noted. "In that way, insurers and health systems will have accurate information for their provider directories."

To identify incorrect data, members of the alliance are sharing their directories and using blockchain to identify anomalies and other issues.

Matching Information

"When sharing their own directory information, members of the alliance can look to match the information each member has with the information that comes from other members," stated LaPenna. "We're trying to find either a positive or a negative match. The more positive matches we have, the greater the likelihood that we have accurate data.

"The reason we started with directory information (names, specialties, addresses, and phone numbers) is that it's easier to confirm that type of information than it is to confirm each patient's or each physician's information," LaPenna explained. "From there, we'll proceed to sharing other forms of data."

Sharing similar directory information among different health insurers and different provider organizations requires all companies sharing the data do so using the same format. To understand the problem, LaPenna suggested that sharing data can be foiled if similar data are entered randomly. When shared data are entered into matching fields, then those processing the shared information can proceed smoothly.

Sharing Information

"As long as the information is shared consistently so that mapping of the various fields can happen easily, then the individuals viewing that information among the different members of the alliance can share that data within their systems appropriately and will not need to manipulate or massage the data before or after sharing it," LaPenna commented.

How Blockchain Works and How It Could Be Useful in Healthcare for Clinical Laboratories

BLOCKCHAIN TECHNOLOGY was among the technologies the inventors of Bitcoin used in 2009 when developing the world's first open-source cryptocurrency.

For a definition of blockchain, the website *TechTerms.com* says the following:

Each transaction added to a blockchain is validated by multiple computers on the Internet. These systems—which are configured to monitor specific types of blockchain transactions—form a peer-to-peer network. They work together to ensure each transaction is valid before it is added to the blockchain. This decentralized network of computers ensures a single system cannot add invalid blocks to the chain.

When a new block is added to a blockchain, it is linked to the previous block using a cryptographic hash generated from the contents of the previous block. This ensures the chain is never broken and that each block is permanently recorded. It is also intentionally difficult to alter past transactions in blockchain since all the subsequent blocks must be altered first [by other computers on the peer-to-peer network].

In healthcare, blockchain is a new and relatively untested technology. It may have value in preventing data breaches of consumer's protected health information or to limit what hackers can get when they launch attacks on healthcare providers' information systems.

In December, the alliance said in a news release, "Following its initial launch in April, Synaptic Health Alliance is deploying a multi-company, multi-site, permissioned blockchain."

Permissioned Blockchain

In a report, the alliance said the choice to use a permissioned blockchain rather than an anonymous one is crucial to the alliance's success. Permissioned blockchains have a higher level of control over access to the blockchain.

The members of the Synaptic Health Alliance can deploy blockchain nodes based on their individual requirements. Some members can deploy their nodes within their own data centers, while others are using secure public cloud services, the alliance said. Such flexibility is a key to growing the alliance's blockchain network, it added.

For clinical laboratories considering how they can use blockchain, LaPenna advised lab directors and pathologists to become aware of how blockchain is being evaluated today. "Clinical lab directors or pathologists should ask how their partners in healthcare are innovating and preparing for the future regarding blockchain," he said. "They should ask how it can be applied effectively and what specific problems it can solve for them.

"The first questions to ask are: What are the specific benefits of blockchain in the healthcare environment and what is its potential for improving member and provider information," suggested LaPenna. "Also, of course, is the important question of how can we use blockchain to remove costs from the healthcare system? That's paramount, and blockchain has the potential to help do that."

Clinical lab administrators and pathologists should use this intelligence briefing as a trigger to do two things. First, is to contact payers about their plans to use blockchain. Second, is to develop a blockchain strategy for their lab. **TDR**

—Joseph Burns

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Labs Should Heed Lessons from Huge Data Breach

PHI of 20 million patients from four of nation's largest clinical lab companies was compromised

CEO SUMMARY: Following news last month about the biggest breach of personal health information in the clinical lab industry, lawyers representing some of the affected patients filed at least 12 class action lawsuits. Federal officials and attorneys general in multiple states also launched investigations. The breach occurred when hackers gained access to the data systems of a bill-collector vendor used by the four lab companies. An attorney advised clinical labs to review how they and their vendors handle PHI.

DATA BREACHES AFFECTING TWENTY MILLION PATIENTS of four of the nation's largest laboratory companies are classic examples of why healthcare providers need to monitor the work vendors do on their behalf.

In June, these clinical laboratory companies reported breaches of personal health information (PHI):

- **BioReference Laboratories** (a subsidiary of **Opko Health**),
- **Laboratory Corporation of America**,
- **Quest Diagnostics**, and
- **Sunrise Laboratories** (a division of **Sonic Healthcare USA**).

The laboratory companies had sent patients' data to the **American Medical Collection Agency** (AMCA), a medical bill and debt collector in Elmsford, N.Y. These labs were among AMCA's largest clients, according to published reports. Within days of the announcement of the breach, AMCA filed for protection under Chapter 11 of the U.S. Bankruptcy laws. *(See "BRLI, LabCorp, Quest Disclose Data Breaches of 20M Patients," TDR, June 10, 2019.)*

In its filing with the U.S. Bankruptcy Court for the Southern District of New York, AMCA said its data were hacked over seven months from about Aug. 1, 2018, to March 30 of this year. The hackers stole patients' records from the four lab clients, plus **CareCentrix** (a home care provider).

In June, attorneys general in at least six states—Connecticut, Illinois, Michigan, Minnesota, North Carolina, and New York—said they were investigating the breach.

Stolen Data Offered for Sale

Hackers collected patients' names, Social Security numbers, addresses, dates of birth, and payment card information, all of which was later advertised for sale in underground web forums, according to reporting by Charlie Osborne of *ZD Net*.

To help lab managers and pathologists understand their lab's responsibilities to safeguard patients' PHI under federal and state laws, THE DARK REPORT interviewed James Giszczak, an attorney and co-chair of the Data Privacy and Cybersecurity Group, at **McDonald Hopkins**.

"One important lesson from this data breach is how critical it is for clinical labs and pathology groups to be proactive in making sure they review their vendor agreements," said Giszczak. "In that review, labs need to know the specific measures each vendor is taking to protect the information the lab is providing to their vendors."

Under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, healthcare providers may be liable for damages when a vendor's systems are breached.

"When a lab's vendor has some type of breach, the lab entity that provided the compromised information could have some liability related to the breach, he explained. "That's why every lab should be proactive and do a review to understand each vendor's policies, procedures, training, and response in the event of a breach.

"Because your lab needs to know how a vendor will respond to a data security incident, and importantly, how quickly it will respond, it's critical for lab officials to review the contracts they have with vendors that acquire, or have access to, PHI," he added.

Delay in Notification

"One issue in the AMCA breach is that the incident started in 2018 and the lab companies weren't notified until June of this year," Giszczak said. "This delay, however, could be attributed to a thorough forensic investigation or even a law enforcement hold."

The labs now face class-action lawsuits from patients who were not informed of the breach until recently. But, of course, the labs may have faced class-action lawsuits regardless of when they were informed of the breach. *(See sidebar, "After Data Breach, Firm Files Bankruptcy Action," on page 15.)*

"If a vendor has any type of data incident involving PHI, your lab needs to be notified quickly, efficiently, and appropriately—typically within 24 to 48 hours," noted Giszczak. "Although a data incident is not necessarily a data breach, you want to be informed quickly so that you can conduct the appropriate and timely analysis to make that determination.

"That vendor may still be working to determine whether the incident was a breach and not an incursion," he said. "But does your lab want the vendor to make that decision, or do you want to be involved in making that decision? Ideally, you want to understand the facts of what's going on and make your own decision.

Vendor Compliance

"Two other important steps include, ensuring that your vendor has appropriate insurance policies in place that cover PHI breaches, and confirming that vendors comply with laws governing the protection of patients' information," he recommended. "To do that, every lab needs to ensure that all critical provisions are covered in each contract it has with each vendor.

"By being prepared, labs can save themselves many headaches," Giszczak noted. "Ultimately, these proactive steps may help laboratories save time, money, and costly bad publicity.

"Over the years, hackers have become more sophisticated and their attacks have become harder to detect," he added. "In addition, even when an organization detects an intrusion into its systems, there may be reasons that could prevent the vendor from notifying the public or its business partners.

"Take the example of a law enforcement investigation," he said. "The investigators may order your lab's vendor not to disclose anything until law enforcement gathers the appropriate evidence or information it needs.

"Other times, a vendor may be unaware that the attack happened. Or the vendor may be aware that an attack happened, but may not be sure if any data was accessed," stated Giszczak. "Thus, while it may appear on its face that there was a delay in the vendor notifying your lab, there may be legitimate reasons for a delay."

State laws are another factor that every clinical lab and pathology group must consider. "Some state legislatures have passed laws expanding what constitutes personally identifiable information," he commented. "In those states, when a lab has a data incident, officials will consider more types of information as personally identifiable information that require heightened protection and may also require notification to individuals and regulators if it is compromised.

"Some states are saying, for example, that information such as usernames and passwords are covered under data-protection laws," Giszczak said. "Such laws increase the regulatory burden on all companies, including labs."

In May, for example, New Jersey Gov. Phil Murphy signed a bill into law to expand the definition of personal information if a breach involves a username or password, he said.

New Jersey's Law

"Previously, New Jersey had defined personal information to include an individual's first and last name, along with any of the following data elements: Social Security number; driver's license number or state identification number; or account number or credit card number in combination with any required security code, access code, or password that would permit access to an individual's financial account," Giszczak wrote in an alert to McDonald Hopkins clients.

Quest Diagnostics is based in New Jersey and Sunrise Medical Laboratories has a patient service center in New Jersey, and so could be affected if this law were in effect before the breach. The law will not be effective until Sept. 1, added Giszczak.

"This updated New Jersey law amends the definition of personal information to include an individual's user name, email address, or any other account holder identifying information, in combination with any password or security question and answer that would permit access to an online account," Giszczak said.

"Other states have either passed or are considering similar laws," he added. "So, it is important for lab companies that operate in multiple states or that have vendors operating in other states to be aware of these laws." TDR

—Joseph Burns

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After Data Breach, Firm Filed Bankruptcy Action

FOLLOWING THE DISCLOSURE that hackers had stolen the personal health information of 20 million patients from a bill-collector vendor for four lab companies, the vendor filed a bankruptcy action.

In a petition filed June 17 in the U.S. Bankruptcy Court for the Southern District of New York, the parent company of American Medical Collection Agency (AMCA) sought relief under Chapter 11 of the Bankruptcy Code. Russell H. Fuchs, founder and CEO of AMCA's parent company, **Retrieval-Masters Creditors Bureau**, said AMCA learned of the breach in March.

AMCA's petition said it received a series of notices from credit card companies suggesting "that a disproportionate number of credit cards that at some point had interacted with the debtor's web portal were later associated with fraudulent charges." Such notices could indicate that hackers had tried to use stolen credit card and customer data. At that point, AMCA shut down its patient payment portal, said AMCA.

"Almost immediately upon learning of the breach, LabCorp unqualifiedly and indefinitely terminated its relationship with the debtor [AMCA]," the petition said. "Soon after, Quest Diagnostics, **Conduent Inc.**, and CareCentrix Inc. which together with LabCorp were the debtor's four largest clients, stopped sending new work to the debtor, and all terminated or substantially curtailed their business relationships with the debtor."

AP Practices Cautioned to Focus on Expenses

➤Anatomic pathologists often pay close attention to revenue while ignoring their group's spending

➤➤CEO SUMMARY: Reviewing an AP practice's expenses is vitally important today when payers are cutting reimbursement. In the past, government and private payers paid more for the technical and professional components of anatomic pathology work, but those rates have eroded. While conversations about revenue tend to obscure the need to talk about expenses, effective financial management is not solely about revenue because every dollar cut from spending will increase net income.

THIRD IN A SERIES

PHYSICIANS IN PRIVATE PATHOLOGY GROUPS often complain that they work harder today than they have in the past and yet they get paid less, observed Al Sirmon, a founder (along with Chappy Manning, RN, CPC, CPMA) of **Pathology Practice Advisors** in Columbia, S.C.

As a consultant to anatomic pathology practices, Sirmon hears this complaint whenever the conversation turns to payment for AP services, in part because it's mostly true. Payment for common AP codes have declined in recent years. Yet there are strategies anatomic pathologists can employ to ease the financial pain.

"When I consult with AP practices, I emphasize the importance of giving equal attention to both income and expenses," Sirmon said. "It's natural to want to spend time talking about ways to increase revenue. That's because reviewing expenses is not as glamorous as looking at revenue.

"Nonetheless, it's critically important today, in part because you can also boost profit by reducing expenses," he commented. "Before 2012, for example, pathologists used to get $60 for the technical component of a CPT 88305, a surgical pathology procedure. That $60 was enough to cover a lab's costs easily. Then, almost overnight, most payers cut that payment to $30, thus making it imperative to look at cost and ways to reduce expenses.

➤Cost to Provide Services

"Effective financial management is not solely about the revenue a pathology group generates. It's also about the group's cost to provide its services," observed Sirmon.

"Assume the group admitted a new partner last year by promoting an associate physician to partner," he noted. "The associate thus went from a lower-paid position to a higher-paying job. That factor alone could explain why pathologists in this group feel as if they work harder and get paid less.

"The expense side of the pathology practice plays a major role in how much income is available for pathologist compensation," he continued. "Groups should look at all types of expenses that make up the expense section of the income-and-expense statement.

"The income-and-expense statement allows an AP group to compare what

it spends for certain services against the revenue generated from those services," he said. "Doing so allows pathologists to identify which services generate the most profit and which services fail to generate enough revenue to cover their associated costs."

In the first two articles in this series, Sirmon outlined the steps anatomic pathologists can take to identify potential sources of new revenue. *(See, "AP Groups Can Protect Revenue, Pathologist Compensation," TDR, April 8, and "Improve Your AP Group's Financial Performance," TDR, April 29.)*

In this installment, he outlined how practices can manage expenses more effectively. "When a pathology practice examines its expenses, it should use a classified income statement," said Sirmon. "This is a critical step for any group's financial analysis as every dollar cut from the expense side drops directly to the bottom line and shows up as an increase in net income. It's not an increase in revenue but it serves the same purpose."

A classified income statement is usually more condensed than an unclassified income statement, but it is more meaningful than an unclassified income statement that simply lists the expenses alphabetically. *(See sidebar, "Why Pathology Groups Should Classify Their Expenses," page 18.)*

Major Expense Categories

"On a classified-income statement, we classify expenses into the following major categories: cost of goods sold (technical component); selling, general and administrative expense; and physician expenses.

"The cost of goods sold is the cost to produce a slide," he noted. "This number includes the cost of equipment and stains and any staff who prepare slides for the technical component.

"We also have expenses classified as, selling, general, and administrative (or SG&A)," he continued. "Cost of goods sold and selling, general, and administrative, are those expenses incurred before the group pays its physicians, which is classified as physician expense.

"When preparing a classified-income statement, experience has taught me that one of the most important costs are the salaries and benefits of the technicians," he said. "Those costs, together with the cost of the stains and the slides, go into the section 'cost of goods sold.' In this section, the pathology group collects all costs related to preparing slides.

Buying Slides from Hospital

"Some pathologists work in hospital labs where they don't own the equipment and they don't make their own slides," Sirmon commented. "Instead, they buy those slides from the hospital for their outreach work. We include those costs as purchased services, which is included in the cost-of-goods-sold section on the expense side of the financial reports.

"Often, it's useful for pathologists who work in hospitals where they buy the slides from the hospital for their outreach work to perform a make-versus-buy analysis," he noted. "In this exercise, the pathology group compares what it pays for the slides the hospital histology lab produces with the costs the pathology group would incur if it established a free-standing histology lab outside of the hospital and made its slides there.

"Many groups we work with have their own independent labs," Sirmon commented. "These labs hire their own histotechs, they own the equipment, and prepare the slides themselves.

"Costs incurred on those short histology production lines are high," he said. "Many AP groups today use IHC stains, some of which are very expensive. In addition, histotechs who prepare those slides are high-priced staff.

Slide Production Costs

"One way to understand the cost of producing a slide is to look at the actual costs from the ground up," Sirmon added. "What does the blank slide itself cost? What do the stains cost? How much time does it take to prepare a slide?

"Analyzing costs this way is the typical method, but there is a better way," he suggested. "It is best to look at what the group actually spent to produce slides in a year. Then compute the average cost per slide.

"For example, it doesn't matter how much stain is used per slide if that inventory of stains sits on a shelf and expires," Sirmon reasoned. "It's much better to look at the total cost over the year that the group spent on supplies and labor and compute the average total cost.

"Actual costs will include all stains—even those that were not used and are still in inventory," he said.

"Also, be aware that often pathology costs in a hospital lab may get blended in with the hospital's costs to run the clinical lab, or they might be included in the microbiology lab's costs," he noted. "Those numbers need to be separated from the AP costs.

Identifying Each Cost

"It's important to know exactly which costs the group incurs for the work it produces," noted Sirmon. "We categorize all expenses and total those numbers. Total cost of goods sold and selling general and administrative expenses are subtracted from revenue to give us the income before physician expense. This is the number that the physician-partners will split.

"Once a pathology group has this classified income and expense statement, we recommend that it classify income and expenses into departments," he continued. "Every AP practice should have at least two departments: one for hospital patients and one for outreach. With those numbers, it's easy for the pathology group to compare the income to expense by each department.

"A final recommendation is for the pathology group to do a detailed comparison of its hospital income versus its outreach income," advised Sirmon. "We make this suggestion because a pathology group's outreach program typically requires the additional payroll costs of sales people and the client service personnel who talk to referring physicians, plus other costs. All of that adds to the expense of doing outreach work, but not when serving inpatients." TDR

—Joseph Burns

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Why Pathology Groups Need to Classify Their Expenses

Once an anatomic pathology practice has categorized all of its expenses, the next step is to match them to their corresponding revenue centers, said Al Sirmon of Pathology Practice Advisors. "Every AP group has three big revenue centers:

1) Histology (88300 through 88309 codes),
2) Special stains (88312 and 88313),
3) IHC stains.

"By matching expenses to income, the AP group can understand the level of profitability of each revenue center, Sirmon explained. "To match expenses to revenue, the group should take the cost of special stains and compare that number to the revenue paid to the group for CPT codes 88312 and 88313 for the year.

"Next, the group does the same for IHC stains," he added. "These steps are important because one or more of the group's payers may not pay much for IHC stains. It is also good financial practice for the group to break out its expenses by cases, by blocks, and by other CPT codes.

"Once the group knows its costs to produce each service it delivers, it can either cut those costs, if possible, or ask insurers to cover more of those costs, if necessary," he said. "If this analysis is never done, the group may never know which services do well—meaning they generate a healthy profit—and which do poorly—meaning this service is losing money or barely breaking even."

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

In Houston, news outlets report that **MD Anderson Cancer Center** was cited for serious deficiencies and the potential for patient harm, following inspections by officials from the federal **Centers for Medicare and Medicaid Services** (CMS) and the **Texas Department of State Health Services**. After an adverse patient event involving transfusion services that occurred in December, 2018, the hospital notified CMS. The inspections resulted from that notice. The *Houston Chronicle* reported, "The state and federal investigations revealed serious problems related to nursing care, laboratory services, patient rights, quality assurance and performance issues, and institutional oversight." THE DARK REPORT will provide additional information about this ongoing story in future issues.

ACCUMEN ACQUIRES HALFPENNY

On June 17, **Accumen Inc.** of San Diego, announced the acquisition of **Halfpenny Technologies Inc.**, of Blue Bell, Pa. Halfpenny provides a range of connectivity and other services for clinical laboratories, physicians, hospitals, health insurers, and others. Halfpenny was founded in 2000 by Charles Halfpenny, who is expected to continue with the company following its acquisition by Accumen.

TRANSITIONS

- **LabCorp** of Burlington, N.C., announced that David P. King would retire on Nov. 1 from his current role as President and CEO. He will continue to serve as Executive Chairman of LabCorp's Board of Directors. Before joining LabCorp in 2001, King was an attorney with **Hogan & Hartson** and an Assistant U.S. Attorney with the **Department of Justice**.

- Adam H. Schechter will become LabCorp's new President and CEO, effective Nov. 1. Schechter has served on LabCorp's Board of Directors since 2013. He currently holds a senior executive position at **Merck & Co.**, where he has worked for the past 30 years.

- **Veravas, Inc.,** of Charleston, S.C., named Carmen Wiley, PhD, as its Chief Clinical Officer. Wiley is currently President of the **American Association of Clinical Chemistry**. She has held positions at **Roche Diagnostics**, **PAML**, and **Marshfield Clinic**.

- Puneet Sarin is the new Worldwide President for **BD Biosciences**, effective June 17. He formerly worked at **Beckman Coulter**, **Leica Biosystems**, and **GE Healthcare**.

That's all the insider intelligence for this report. Look for the next briefing on Monday, July 22, 2019.

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UPCOMING…

- *More Insights from Pathologists Who Authored JAMA Study about the 17% Decline in U.S. Pathologists Since 2007.*
- *Lessons from a Health System Lab's 10-Year Journey to Build Profitable Outreach Business and Show Value.*
- *New Breakthroughs in Population Health Management: What All Labs Need to Know about Smart Use of Lab Data.*

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