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From the Desk of R. Lewis Dark...

THE DARK REPORT

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

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COMMENTARY & OPINION by...

R. Lewis Dark
Founder & Publisher

PAMA Fee Cuts a Factor in Outreach Lab's Sale

THROUGHOUT THE WORLD, THE UNITED STATES IS ENVIED for the quality and ready access to medical laboratory tests that it delivers to physicians and their patients. Yes, there are criticisms that healthcare costs too much in this country compared with costs in other nations. But few countries offer both convenient access to testing services and the full menu of state-of-the-art diagnostic tests that are common in this country.

Unfortunately, administrators at the federal **Centers for Medicare and Medicaid Services** (CMS) seem to be taking the first steps on a path that could cause this valued healthcare asset—convenient patient access to high-quality lab tests performed locally—to deteriorate and break apart. This consequence will result from their implementation of the private payer market price reporting rule under the Protecting Access to Medicare Act and the deep cuts to Medicare Part B fees they intend to enact on Jan. 1, 2018.

First evidence that the proposed Medicare lab test fee cuts will cause community labs and hospital lab outreach programs to go out of business surfaced last week. **PeaceHealth** of Vancouver, Wash., announced an agreement to sell its successful lab outreach business to **Quest Diagnostics Incorporated**. The outreach lab company, **PeaceHealth Laboratories**, provides services to communities throughout Oregon, Washington, and Alaska. It employs 906 people and PeaceHealth has already acknowledged that 500 people will be "affected" (translation: laid off) by the sale. Quest may rehire an unknown number of these individuals.

This sale is significant. The CEO of PeaceHealth Laboratories, Ran Whitehead, in an interview with THE DARK REPORT, describes how the PeaceHealth administration, following enactment of PAMA in 2014, began modeling the financial effect of cuts to Medicare lab test fees on the lab's financial sustainability. As you will read on pages 3-9, the conclusion was that PeaceHealth's lab outreach business would be unable to continue with the needed cash flow and capital to sustain clinical quality and lab test services at acceptable levels. Thus, the decision to sell the lab before CMS instituted cuts to Medicare lab test fees.

Officials at CMS should pay close attention to this hospital lab outreach sale. It is the first example of what could be a wave of closures, bankruptcies, and forced sales that will happen as the Medicare fee cuts cripple community labs and the lab outreach programs of small and rural hospitals. TDR

PeaceHealth Labs Sold To Quest Diagnostics

Quest buys lab outreach business, to run inpatient labs in 10 PeaceHealth hospitals

CEO SUMMARY: In Oregon, one of the nation's more successful and long-established health system outreach laboratories will cease to exist following its sale to Quest Diagnostics Incorporated. The seller explained that the Medicare Part B price cuts coming as a result of the PAMA market price reporting rule would result in a 20% revenue decline in 2018. This sale, and the reason for it, is first evidence of how the rule CMS crafted has the potential to disrupt the financial stability of community labs.

ANOTHER MAJOR HEALTH SYSTEM has sold its laboratory outreach business. On Feb. 15, **Quest Diagnostics** announced an agreement to acquire **PeaceHealth Laboratories** and to manage the inpatient labs of the hospitals **PeaceHealth** operates in three states.

Price and terms of the agreement were not disclosed. The sale is expected to close during the second quarter of this year.

PeaceHealth Laboratories is the lab outreach business of PeaceHealth, a nonprofit healthcare system based in Vancouver, Wash. The system has 10 medical centers serving patients in Alaska, Oregon, and Washington. In all three states, Quest Diagnostics will acquire PeaceHealth's outreach laboratory business except in communities where PeaceHealth operates critical access hospitals.

When the sale closes, one of the nation's oldest and consistently successful lab outreach programs will disappear. The lab has 906 employees working in 11 laboratories and 27 patient service centers. Its central laboratory is in Springfield, Ore., next to Eugene and employs about 400 people.

One of the nation's largest mid-size lab businesses, PeaceHealth Laboratories is widely respected for serving patients with efficiency and low-cost lab testing services. So why did this health system decide to sell its lab operations?

In an interview with THE DARK REPORT last week, Ran Whitehead, President of PeaceHealth Laboratories, explained that the lab and health system's leadership projected the effect that the Protecting Access to Medicare Act (PAMA) would have on clinical lab test-

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ing payments starting next year. From those projections, the administrators determined that—just as other similar mid-sized laboratories have decided—PeaceHealth Laboratories would see a decline in reimbursement of 20% starting in 2018 and continuing into future years. *(See related article, pages 6-9.)*

Negative Effects from PAMA

The change in ownership of the lab will have a direct effect on 500 of the more than 900 lab employees. In local news coverage of the agreement, Dylan J. Darling of the *Register Guard* newspaper in Eugene, reported that some 500 PeaceHealth lab staff members would likely be laid off when the deal is complete this spring. Quest plans to hire 275 lab staff members in Oregon and Washington, he added.

Darling quoted PeaceHealth CEO Rand O'Leary saying, "Our intent when this is all said and done is to try and place as many people as we can in positions with PeaceHealth or Quest."

The search for a buyer began two years ago when lab and health system administrators acknowledged that their lab business faced increased competition and regulations and needed sustained capital investment for technology. At the time, PeaceHealth began to assess those lab companies nationwide that might be a good fit as a partner or a buyer.

Long-Term Solution Needed

"The aim was to determine the best way to provide laboratory services in the most appropriate, sustainable manner," PeaceHealth announced. "In other words, a long-term solution was needed to meet the growing service and technological needs of our communities, as well as the caregivers and providers with whom we serve." After meeting with a number of lab companies, PeaceHealth decided that the best long-term solution was to sell to Quest Diagnostics.

Along with the announcement, PeaceHealth provided a list of questions and answers, including the question of whether this sale indicated that PeaceHealth was in financial trouble. "No. PeaceHealth is financially strong and stable," the company said. "By working with Quest, PeaceHealth will ensure long-term access to sustainable delivery of high-quality laboratory services within our communities as we continue in our call to promote personal and community health."

The sale of this respected health system lab outreach business has important implications for the clinical laboratory industry. For example, similar to the assessment at PeaceHealth, other lab executives and hospital lab administrators are acknowledging that the coming Medicare Part B fee cuts under the PAMA market price reporting rule will undermine the financial stability of their labs. At PeaceHealth, the financial consequences of the coming fee cuts played a significant role in the decision to sell the outreach business.

Lab Outreach Business Sold

The decision of a major hospital system to sell to one of the national lab companies and thus exit the laboratory outreach business is early evidence that critics of CMS' PAMA market price reporting rule may be correct. Those critics predicted that the nation's community labs and hospital labs will struggle financially and some may close. The beneficiaries of this market development would be the nation's largest lab companies.

Following the sale, the buyer intends to close the community labs that PeaceHealth Labs currently owns and send the specimens elsewhere. Thus, not only will loyal, long-serving lab employees be laid off, but physicians and patients, including Medicare beneficiaries in these communities, will lose access to lab testing performed locally. TDR

—Joseph Burns

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Two Northwest News Outlets Report Possibility That a Sale of PAML to LabCorp Might Be Close

IN OTHER NEWS FROM THE PACIFIC NORTHWEST, at least two reports surfaced last week that **Pathology Associates Medical Laboratories** of Spokane, Wash., would be sold to **Laboratory Corporation of America**.

Both the *Lund Report*, which covers healthcare in Oregon, and the *Spokesman-Review* of Spokane, reported that the sale was imminent. No sale was confirmed, however, in either of the news articles.

"**Providence Health & Services** is also planning to announce the sale of Pathology Associates Medical Lab which it owns in collaboration with **Catholic Health Initiatives**, a minority shareholder, but the timeline is unclear," wrote Diane Lund-Muzikant of the *Lund Report*.

Writing for the *Spokesman-Review*, Scott Maben picked up on the *Lund Report* article and wrote, "PAML, the national medical-testing laboratory based in Spokane, is on the brink of sale to LabCorp, the world's leading healthcare diagnostics company, reports an independent news site covering the Northwest health care industry."

The current owners of PAML are Providence Health & Services and **Catholic Health Initiatives**. The lab company has more than 1,600 employees and collects specimens from patients from eight states to generate annual review of approximately $300 million, he wrote.

In a statement to Maben, PAML said, "We have heard that there was an online post that has created questions. However, at this time we don't have any information to share."

In her story, Lund quoted Robert Michel, Editor of *The Dark Report*, who said, "In the Pacific Northwest, there have been continual rumors for more than 24 months now that Providence Health was negotiating a sale of PAML, its gem of a laboratory outreach business, to Laboratory Corporation of America. Many people have pieces of information about the activities of administrators at Providence, LabCorp's C-suite, and executives at PAML during this time that are consistent with sales negotiations. But, in response to questions from the media and others, no one from these three organizations will confirm something as basic as that discussions of PAML's sale between Providence and LabCorp have occurred. Yet, the market chatter is continual and credible, leaving lab industry professionals to believe that some type of deal is under development."

More than two years ago, THE DARK REPORT published a story, "Is PAML To Be Sold? 'No Comment!' Say Execs." At that time, an executive of PAML provided the following statement: "Thank you for your recent inquiry regarding PAML, LLC. As an organization we regularly explore opportunities that would help us improve quality, reduce the cost of care, and enhance patient experience. However, we don't discuss details publicly until all parties involved agree to do so." *(See TDR, December 15, 2014.)*

On LabCorp's quarterly conference call last week, an analyst asked CEO David King the same question about the rumors of PAML's possible sale. King's response was, "Well, I'm not going to comment on anything about any particular transaction. And I think to some extent we've responded to this question earlier, which is the pipeline is robust and there is new interest from health systems generally and more broadly. In terms of strategic opportunities, that may include sale or it may include broader partnerships."

Is PAML for sale? Is LabCorp the likely buyer? The non-stop chatter throughout the Northwest for more than two years is associated with the movement and meetings of executives from these organizations. These activities are the visible evidence that something might be happening. On the other hand, because no executive at these organizations has been willing to definitely state, "No sale is under discussion," rumors have persisted.

PAMA Data Projections Led to Decision to Sell Lab

Starting in 2018, lab expects Medicare pay rates will decline by 20% over 2 to 3 years

CEO SUMMARY: Following passage of the Protecting Access to Medicare Act of 2014, officials at PeaceHealth and PeaceHealth Laboratories began to model the financial effect this law would have on this long-established hospital lab outreach program. Based on projections of a 20% cut in revenue during the first two to three years of the Medicare Part B fee cuts that will take place starting in 2018, the health system decided to sell its lab outreach program to Quest Diagnostics.

FOR TWO YEARS, officials at **PeaceHealth** considered how to get the most value from their extensive clinical laboratory operations in the Pacific Northwest.

Those discussions began in 2014 after the U.S. Congress passed the Protecting Access to Medicare Act of 2014 (PAMA). It was clear that PAMA would have a significant effect on Medicare payments for clinical laboratory tests.

But how significant was not apparent until the federal **Centers for Medicare and Medicaid Services** published the draft rule to implement the private payer market price reporting section of the law in 2015, followed by the publication of the final rule last year. After reviewing the final rule, clinical labs began to forecast how the rule would affect lab payments. *(See TDRs, Oct. 5, 2015, and July 5, 2016.)*

Consultants to the clinical laboratory industry predict that the PAMA private payer market price reporting rule will result in steep cuts in payment for lab tests, cuts of as much as 20% off current reimbursement levels. THE DARK REPORT published an analysis from **XIFIN Inc.,** a company in San Diego that provides revenue cycle management to more than 200 clinical lab organizations. In this analysis, XIFIN determined that the independent lab companies in its client portfolio were paid a weighted average of 19.6% less than what private payers paid for Medicare Part B fees for 20 of the highest-volume tests. *(See TDRs, Nov. 7 and Nov. 28, 2016.)*

Sale of Lab Announced

These projections, as well as statements by CMS officials that the market price reporting rule would generate fee cuts of $400 million in 2018 and $5.4 billion over 10 years, were significant reasons PeaceHealth announced last week that it would sell **Peacehealth Laboratories**—its successful laboratory outreach program—to **Quest Diagnostics Incorporated**.

"Absolutely, PAMA was part of our thinking," declared PeaceHealth Laboratories President Ran Whitehead in an interview with THE DARK REPORT. "It wasn't the only criteria, but it was a significant part of our discussions.

"As we began to look at the resources we would need to acquire the additional lab equipment, diagnostic technology, and informatics solutions required to support the population health management needs of our parent health system, we began to consider the need for a partner for our clinical lab business," he said.

Deep Cuts on the Horizon

"Our estimate was that we faced a significant drop in the reimbursement rates for laboratory tests, beginning in 2018," Whitehead commented. "Our first thought was to see if we could partner with a lab company to help get us through this change over the next few years. We wanted to keep PeaceHealth Laboratories as a clinical service resource for our hospitals and the physicians and patients we serve, many of which are in very rural areas of the Pacific Northwest.

"To fulfill the mission of PeaceHealth, our outreach lab operates patient service centers that are in rural locations," he added. "As an example, for our operations in Alaska, we must fly specimens on aircraft and sometimes float planes. All of this takes resources.

"The trouble is that we're in an environment where the future reimbursement for clinical lab tests is in question," observed Whitehead. "Most lab people across the country believe they will see some significant cuts in Medicare payments for lab tests in the first two to three years of PAMA. Those cuts will start on Jan. 1, 2018, just 10 months from now.

Balancing Costs and Quality

"We share some of the common thinking in the lab industry that payments could go down by 20%," he explained. "Of course, the specific amount depends on your lab's existing fee schedule, payer mix, and your current reimbursements for lab tests.

"Some labs will be affected more than others," explained Whitehead. "Here at PeaceHealth Laboratories, our best

How CMS' Final Rule Is Biased, Will Collect Only Lowest Prices

LAST SEPTEMBER, A REPORT WAS ISSUED by the **Office of the Inspector General** (OIG) that described what the federal **Centers for Medicare and Medicaid Services** was doing to implement the PAMA private payer market price reporting rule.

The OIG noted that just 5% of the nation's labs were paid 79% of the total amount of Medicare Part B lab test payments in 2015. In the final rule CMS issued, labs required to report were identified by the OIG as follows:

- **1,398** of 3,211 **independent labs** (includes hospital labs with NPI numbers); excludes 56.5% of independent labs from reporting.
- **11,149** of 235,928 **physician office labs**; excludes 95.3% of POLs from reporting.
- **0** of 6,994 **hospital labs**; excludes 100% of hospital labs without an NPI number from reporting.

The exclusion of large numbers of community labs, POLs, and hospital labs from reporting the prices private health insurers pay means that CMS will not be getting data from those labs in the United States that are known to get higher prices from private payers.

Private payers understand that these labs have smaller volumes, and thus higher costs. But payers need these POLs, community labs, and hospital labs to be in their provider networks in order to provide access for their beneficiaries.

By excluding these labs from reporting the higher prices they are paid by private health insurers, CMS has gamed the system to ensure the incoming market price data is mostly made up of the lowest lab test prices insurers pay to the nation's highest-volume labs. In this manner, CMS believes the data it collects will support deeper cuts to Medicare Part B lab test price cuts.

projections indicated that we would experience about a 20% reduction in revenue just in the first two to three years of the PAMA Medicare fee cuts that will begin next year.

Sailing to Uncharted Waters

"There is no way smaller labs and hospital lab outreach programs have a profit margin sufficient to absorb a 20% reduction in lab test fees," he continued. "Not everyone's fee schedule is tied to the Medicare fee schedule, but many labs like ours are paid either off the Medicare fee schedule or their insurance contracts pay some percentage of that fee schedule.

"The net effect is that these PAMA Medicare Part B fee cuts will have a sizeable financial impact on most everyone, particularly those hospital outreach labs serving rural communities and that means small to mid-size laboratories such as ours," he said. "These price cuts probably will not have such a significant effect on the big players.

"PeaceHealth Laboratories runs about 8 million lab tests annually and that puts us somewhere between a mid size and large lab," he commented. "We're certainly not in the same category as Quest Diagnostics, **LabCorp**, **Mayo**, or **ARUP**. We're probably in the next tier down from that group of the largest labs.

"Like all labs, we have certain fixed costs and if we hadn't done this arrangement with Quest, we would be forced to consider changing our service level offerings when these reimbursement declines start next year," Whitehead said. "We've already done what we can to improve our operating efficiency. All of our labs are integrated on one IT platform, and we have common instrumentation.

"That's what got us through the first wave of cuts that Medicare put in place about five years ago, when CMS cut fees by about 5% per year in three or four consecutive years," he added. "We adjusted to that. But now, when you model the financial consequences of Medicare Part B fee cuts of 20% in two to three years, that's a whole different ballgame—especially after we've already done everything we can to make our laboratories more efficient.

"Our hospital lab outreach program just doesn't have the scale required to maintain top-flight equipment, technology, and IT prowess," observed Whitehead. "Those are significant capital investments. You don't need to be a CPA to see that the Medicare fee cuts that will happen in just 10 months make it impossible for labs like ours to keep the doors open, let alone have the capital to make needed investments.

"When we looked at our options, that led to questions such as, is this something we can do on our own? Or does this environment require that we partner with someone to make sure at least the communities we serve continue to have lab services?" he asked.

Steep Capital Requirements

"Like all labs, we have to refresh our technology platforms and lab instruments every so often," noted Whitehead. "That is an expensive proposition. We need to regularly acquire new technology, such as the ability to do molecular testing.

"To do that requires both a capital infusion and the need to hire people who have a specific level of expertise," he explained. "When we added it all up, we asked, how are we going to pay for that? How is our hospital laboratory outreach program going to get a return on that investment when it faces such huge reductions in reimbursement? It simply did not make sense.

A Partner Search Begins

"If you can't do it yourself, then you have to look for partners," he noted. "For two years, we did an exhaustive search to find the right partner. That search resulted in our agreement with Quest.

"So now Quest Diagnostics will need to answer those same questions that we

asked," Whitehead continued. "Quest will bring resources and expertise in areas that would have required investment by our lab. It provides the management of the labs and the supplies, equipment, and service. But PeaceHealth still owns those labs and the employees who work in our hospital labs remain our employees.

"Quest Diagnostics can profit from any margin they can get by charging a certain rate for each inpatient test," he said. "It will get our reference test referrals and it will own our lab outreach business. It can thus leverage its economies of scale by folding our outreach test volume into its existing lab infrastructure. Those outreach lab tests will no longer come to PeaceHealth Labs.

"The question we faced in considering this sale was whether we had built in enough performance guarantees so that Quest Diagnostics can be successful in the communities and rural areas we currently serve," Whitehead explained. "We want Quest to succeed because these are our patients it will serve.

"Any partnership or affiliation like this is a two-way street," he added. "That is why we worked hard to ensure that the agreement includes requirements that our quality and service remain at the levels that we've achieved over the last several decades. Quality goals are built into the contract.

"That's part of what took us almost two years to work out in this agreement," he concluded. "Before we ever got into contract negotiations, there was much discussion at the board level of PeaceHealth about defining the criteria for success when developing a partnership for our health system's lab testing needs. This was no overnight discussion. It is a process that took the better part of two years." TDR

—Joseph Burns

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Cuts from Final PAMA Rule Seen as Forcing Big Changes

LAB EXECUTIVES HAVE SPENT MANY hours over the past year or more talking with members of the U.S. Congress about how the rules to implement the Protecting Access to Medicare Act of 2014 will affect clinical laboratories adversely. Those discussions continue even now.

"Over the last couple of years, I've spent a considerable amount of time talking with our congressional delegation in DC and others on Capitol Hill about the impact of PAMA and, in particular, the regulations that CMS put out," stated Ran Whitehead, President of PeaceHealth Laboratories.

"The problem is that the private payer market price reporting rule that CMS wrote excludes a vast number of smaller labs and hospital labs from reporting their private payer prices to CMS," he said. "CMS crafted the final rule in such a way that only larger labs—those that have lower costs and are paid less by private insurers—will be reporting. Thus, the data CMS collects will not show the higher prices that insurers pay to smaller labs across the nation.

"The Medicare Part B fee cuts that CMS already says are coming will have a negative financial impact on small, medium, and semi-large laboratories like ours," added Whitehead. "This is the message we have to deliver to our officials in Congress.

"That message is that PAMA will adversely affect both Medicare beneficiaries' access to care and jobs in the lab business, particularly in smaller towns and rural communities like the ones our lab serves," he explained. "It's important to educate our elected officials why this train needs to get on a different track.

"That is why lab leaders continue to speak to members of Congress because they want to hear from us about how these regulations will affect care to Medicare beneficiaries, along with jobs in their home states," he concluded.

CEO SUMMARY: At the University of Michigan Medical Center, the Department of Pathology is learning new ways to add value that include face-to-face meetings with patients as part of UMMC's patient- and family-centered care initiative. One lesson learned is that patients appreciate the opportunity to get a better understanding of the results from both anatomic pathology and clinical pathology tests. Pathologists see such interaction as a useful part of personalized and precision medicine.

Patients value face-to-face meetings with pathologists

U of Michigan Pathologists Bet on Patient-Centered Care

ALL OF HEALTHCARE IS SHIFTING TO A patient-centered model of delivery. Primary care physicians work in patient-centered medical homes, and specialists are working alongside PCPs in patient-centered neighborhoods.

"It's a natural progression, then, for pathologists to meet with any patient interested in gaining a deeper understanding of their care and explain anatomic and clinical test results," stated Jeffrey L. Myers, MD, Vice Chair of Clinical Affairs and Quality and Director, Pulmonary Pathology Fellowship in the Department of Pathology at the **University of Michigan School of Medicine**.

"In 2013, as a strategic imperative, our pathology department launched several pilot programs to test the concept of delivering patient- and family-centered care (PFCC)," explained Myers, who is Division Director for **MLabs**. "Today, the PFCC initiative at the **University of Michigan Medical Center** is believed to be the largest such program in any pathology department in the nation.

"In this style of care delivery, pathologists learn that patients have important stories to tell us, and those stories inform how pathologists deliver care and interact with patients," he said. "These interactions also help our pathologists to deliver more value.

"We launched these pilot programs based on the anecdotal experience of interacting directly with some of our cancer patients," stated Myers. "This included a pilot project in which one of our hematopathologists held office hours in our regularly-scheduled outpatient lymphoma clinic to provide direct consultation to cancer patients. That was very well received.

"In another pilot, pediatric pathologists meet with families who have lost neonatal children," Myers added. "We can now support those families by providing detailed answers to their questions.

"In one other program, our pathologists collaborate with the university's School of Social Work to have social work graduate students work in the Wayne County Medical Examiner's office in Detroit, an outpost of the university's pathology department," he said. "From that, we've learned how we can deliver better care for families by having a social work capacity in a large forensic practice.

"From these pilot initiatives, we are gaining experience in two ways," stated Myers. "First, we are identifying the best ways to get patients more involved in how our pathologists deliver care to them. Second, we are then using this knowledge to engage patients. Our success with these pilot programs drove our decision to embrace PFCC as a strategic imperative for our pathology department.

"Direct interaction between a pathologist, patients, and their families is largely uncharted territory," he continued. "Thus, our pathologists need to learn the skills required to navigate this aspect of medicine. That is why our pathology department is developing a curriculum to train pathologists, trainees, and staff in how to have difficult conversations with families and patients.

Advisory Council Launched

"Based on what we learned, in July we launched what may be the first patients and families advisory council (PFAC) based in a pathology department," noted Myers. "This council includes seven patient and family advisors (PFAs) who work directly with our pathologists to transform the ways in which our patients and families experience health and disease.

"One way to look at this program is that it involves understanding the things our pathology department left untapped in our quality improvement efforts," he explained. "A couple of years ago we created the Division for Quality in Health Improvement to identify larger opportunities in the inpatient and outpatient settings for pathology to drive value.

"At the moment, our pathology department's focus is less on operational quality and on Lean because we already do both of those well," he added. "Going forward, the question we wanted to answer is this: 'what would patients say that we don't do well?'"

The pathology department's PFCC program is one of about 30 such initiatives in the University of Michigan School of Medicine. "We worked with our institutional colleagues to learn how to understand this work, including how to organize advisory councils of patients," said Myers. "While we took the advice from other departments, we also went outside the rules a bit, such as about the size of our PFCC. We were told that the ideal size is 10 to 12 members of a department.

Much Enthusiasm

"We have about 40 members in our advisory council, in part because—as we discussed this program—we discovered a lot of enthusiasm for this approach and didn't want to discourage anyone from participating," emphasized Myers. "Also, because one of our goals for this program is cultural transformation, we didn't want to close the door to anybody who wanted to be at the table.

"In our PFCC of 40 people, we have seven who are called patient and family advisors," Myers concluded. "These are patients or family members of patients who have volunteered to be part of our patient- and family-centered care program. They want to share with us what it's like to be standing in their shoes. These volunteers are vetted and trained and then are available to respond to questions or participate in surveys."

When patients meet with pathologists at the University of Michigan Medical Center (UMMC) to discuss their care, they are often shocked at what they learn but also are pleasantly surprised and grateful for the depth of understanding they gain.

"These patients say, 'Had we known there were people behind our lab results, we would have wanted to find you," explained Myers. "They also ask, 'Why are you not in a better position to help us understand the information you have and how to apply that information to help us make better choices as we become more vested in our care?'

"When patients ask questions like these about their care, it can have a powerful effect on how pathologists interact with patients and family members," noted Myers, who leads the patient- and family-centered care (PFCC) initiative in the Pathology Department at UMMC.

"There is a huge appetite among patients, family members, and our patient and family advisors who want to understand their laboratory results," he continued. "They make that message loud and clear during these face-to-face meetings.

"Patients know they are cared for by teams of multiple providers with different areas of expertise," he said. "And all of those providers use some laboratory information to come to different conclusions. So patients ask, 'Where are the pathologists and clinical lab scientists who produce this information?'

"They ask a good question, and it's one we are answering here at our medical center," continued Myers. "For these patients, PFCC is the missing piece and—without that approach to care—they're a bit angry that we haven't been around.

Patient Volunteers

"For example, we have one patient who is a very savvy, hard-nosed, healthcare consumer with breast cancer," he related. "She has been disease-free for 10 years and in that time has learned a lot about her condition, about stem cells. She even knows our chief researcher and she might know more about Oncotype DX than I do.

"After I met with her for the first time, she asked why she hadn't met with a pathologist earlier in the course of her care," added Myers. "She asked, 'Could I have met with a pathologist to understand my care?' Well, 'yes,' I said. 'You would have had to work at it, but of course.

"At that point, she wanted to look at her case reports. So I got all of her slides together, even those that were not done here," he explained. "Now, remember, she's a very hard-nosed, tough lady. When

University of Michigan Pathologists Aim To Be At Forefront of Patient-Centered Healthcare

FACE-TO-FACE MEETINGS between pathologists, patients, and their family members have provided many useful insights to the pathologists at the University of Michigan School of Medicine as they develop their departments' patient- and family-centered care (PFCC) program.

"We've learned that not every patient will want such a detailed view of their conditions," acknowledged Jeffrey L. Myers, MD, Vice Chair of Clinical Affairs and Quality, Division Director for MLabs, and Director, Pulmonary Pathology Fellowship in the Department of Pathology. "But as the movement toward personalized medicine becomes more popular among patients, our pathologists are learning that patients want to know more about the cause of illnesses and the prospect for cures.

"Our effort to get pathologists involved in patient- and family-centered care (PFCC) is driven by our conviction that pathology should not be dragged kicking and screaming into the age of patient-centered care," noted Myers. "Instead, we think pathologists should lead the way, especially in those institutions that may be dragging their feet.

Golden Opportunity

"I'm convinced that laboratory medicine is at the precipice of something good and if pathologists pass on this opportunity, other departments will step ahead of us," he added. "If that happens, pathology will lose a golden opportunity to become the patient-centered discipline required for pathologists to be successful in today's rapidly shifting healthcare landscape."

For pathologists, the compelling question about patient-centered care is how to get paid for consulting with patients when clinical and anatomic pathology is viewed as a commodity service where costs must be contained. However, Myers sees the shift away from fee-for-service payment toward capitated and bundled payment as an opportunity for pathologists who consult with patients to demonstrate that they have more value in a patient-centered healthcare system than those who do not deliver patient-centered care.

"This effort is important as pathologists try to understand how we keep a place at the reimbursement table as the fee-for-service payment model diminishes," Myers explained. "I don't know exactly how we're going to get paid for this, but I believe that if we don't figure this out, we may not get paid at all.

Problem To Solve

"Here's the problem we'd like to solve: In the current healthcare system, as providers, we dictate value from what we think it should be," Myers said. "But we don't really understand value from where patients stand. So, as we get better at understanding value from the patient's perspective, we will find ways to add value to care that we have not yet imagined.

"When pathologists learn to do that well, the value of pathology will increase. In turn, it will mean that health systems will be unable to export my job with digital whole slide images to China, India, or elsewhere," he continued. "Exporting what pathologists do will be impossible if patients are saying, 'The best experience I had was meeting with the pathologist who helped me understand things I wouldn't know otherwise.'

"I'm not being overly dramatic when I say that's where the opportunity lies," he added. "If pathology can figure this out, I am absolutely convinced that it will be part of the salvation for pathology services because we will define new value from the perspective of patients in ways that they will not want to live without.

"Who knows what reimbursement will be like 10 years from now?" asked Myers. "We don't know and so in many ways patient-centered care could be what pathology needs in this changing reimbursement environment."

we met in my office to look at her slides on the monitor, she started to cry, which I would not have predicted. I was surprised but fine with it, and asked her to tell me what she was thinking.

"She said, 'There are so many cells. I was told that my cancer had a good prognosis, which made me think that the enemy was small,'" said Myers. "But the enemy was big and I didn't know that. And I wish I had known that at the time.'

"Thinking about what she said, I realized that, other than a pathologist, there is no other person on her healthcare team who can provide that experience," Myers commented. "I suppose a cynic would ask, 'What value did that experience add for this patient?' But that's not for us to define; that's for her to define. And that experience shows that we're not very good at understanding value from the perspective of our patients.

"Here's another example," he added. "We've had patients who learned about our tumor boards and asked why they were not invited. Of course, our reaction is to immediately list all the reasons patients cannot attend tumor boards. And when we offer our reasons, the patients say, 'Well surely you can figure out how to overcome those problems!' And, of course, we can do that.

Patient Volunteers

"Another relevant experience started with an email I got from one of our very well-known breast oncologists," he continued. "'There's a patient who wants to talk to you about her pathology and I've explained why there was a change in the grade of her tumor but she insists on talking to you,' he said. I was happy to talk to her and told him to give her my phone number.

"When the patient called me, she said, 'First, they think they know what I want to learn from you, but they don't. And second, I'm not stupid; I'm a drug rep. I've got a degree and my work in the drug industry is in oncology and particularly breast cancer. I know a lot about my disease,'" related Myers.

"Then she added this: 'I always imagined that—as a pathologist—there must be times when you look into the microscope, see somebody's tumor and think, 'Holy crap, I'm really glad that's not my tumor! And there must be other times when you look in the scope and say, 'If my wife had breast cancer, this wouldn't be the worst one to have.'

Question From Patient

"What she said was true, of course," he added. "That's what we think sometimes. Then she asked, 'Which one was I?'

"I hadn't anticipated that question, but I had her slides right there and I said we could look at them and I would try to imagine I'm looking at them for the first time and answer her question," stated Myers. "I told her, 'Honestly, as breast cancer goes, this isn't a bad one.' And she thanked me. So, there's another example of where no one else on her care team could have told her that! She had to ask a pathologist to get that answer and when she got the answer, she was thankful.

"The point of both of these stories is that whenever you talk about patient- and family-centered care, many physicians and other providers will say, 'Oh, yes, we've been doing that for years.' And certainly they've done many wonderful things for patients," observed Myers. "But they are not doing what we, as pathologists, are uniquely equipped to do.

"That's the point: Historically, pathologists have had the best of intentions to deliver the best care we can for patients," he explained. "The difference in patient- and family-centered care is that you do things with patients. You partner with them directly in their care. That is very different from the traditional practice of pathology."

"How pathologists will get paid for this is an unanswered question," he said.

What University of Michigan Pathologists Learned about Patient-Centered Care, Clinical Pathology

ONE QUESTION ASKED about patient- and family-centered care is whether this method of care delivery works for anatomic pathologists only or for both anatomic and clinical pathologists.

"It's both!" declared Jeffrey L. Myers, MD, who leads the patient- and family-centered care initiative in the Department of Pathology at the University of Michigan School of Medicine. "Very definitely, patients want to know more about their clinical lab results. In fact the appetite for clinical lab test results is at least as great as it is for anatomic results.

"To address that need, our pathologists are developing experience in how we can help patients understand the tsunami of numbers and information that populates their medical records in ways that help them be more directly engaged in their care," he noted.

"In doing that, we heard complaints, such as, 'Well, not every patient wants that.' Of course, that's true," he continued. "We know that. That's why we call it 'personalized care' or 'precision medicine.'

"Our pathologists want to address each patient's individual preferences," commented Myers. "What we are learning is that there is a very large number of patients and families who want to know more about their healthcare because they want to participate in making decisions about their care. However, a huge chunk of their healthcare is embodied in laboratory information that they cannot unlock.

"As the pathology department's contribution to our medical center's patient- and family-centered care initiative, it's our job to try to unlock that information for them," he said.

"We don't get paid to sit with patients and look at their slides. To that, I say, 'No, we don't now, but we will and here's why.'

"Nobody knows exactly how or how much we'll get paid for this care," continued Myers, "But certainly, as bundled and capitated payments increase and as we ask ourselves how will pathology demonstrate its value, we will find a way to be paid for this care.

"If the pathology profession does not do this, then it will continue to be distilled down to a commodity service, which means administrators will compare our fee schedule to that of the large commercial lab companies and the comparison will not look good," Myers explained. "That's why pathologists must find other ways to provide value and—even if we don't get paid for it today—it will preserve pathologists' employment for tomorrow.

"There is the potential that, ultimately, patient- and family-centered care may completely upend the test-ordering algorithm," explained Myers. "Currently we talk about how we can educate physicians to use laboratory resources more effectively. But that's the wrong model. We wouldn't think of telling physicians in any other sub-specialty discipline how to do some other sub-specialty procedure. So, why do we do that differently in the lab?

"That's why the future of our discipline will hinge on how pathologists engage differently with patients and providers," he noted. "The role of pathologists will be to understand the problem physicians are trying to solve for each patient, and we will decide which lab tools will solve that problem. Then, pathologists will use those lab tools and consult with other physicians and with patients directly. When pathologists do that, our profession will be delivering patient- and family-centered care." **TDR**

—Joseph Burns

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Clinical Labs Bidding Up Lab Director Salaries

➤Surprise! Strong demand for medical directors, PhDs who can sign out molecular, genetic tests

➤➤CEO SUMMARY: There's great news for pathologists and PhDs with expertise in molecular and genetic testing. Salaries are on the rise as more clinical labs build up their molecular and genetic testing programs and need talent to implement and supervise this activity. One experienced medical recruiter recently surveyed all the current pathology openings nationally. He determined that the subspecialties of molecular pathology and hematopathology have the highest demand in the hiring marketplace.

IT MAY SEEM COUNTER-INTUITIVE that the compensation for pathologists, PhDs, and medical doctors is climbing even as clinical lab budgets are shrinking and lab test prices are decreasing. But higher compensation packages are the reality in the job market today, asserts a well-known medical recruiter.

"Hiring in the lab business slowed dramatically beginning in 2008, at the start of the deep recession," observed Rich Cornell, owner and founder of **Santé Consulting LLC**, a healthcare search firm in St. Louis. Santé specializes in recruiting pathologists and clinical lab scientists at the director level and above for positions nationwide.

"Each year since 2008, more positions have become available and salaries have been rising," commented Cornell. "When demand for executive and director-level talent outstrips the supply, which is the case today, that's when salaries start to climb.

"Three reasons fuel this increased demand for lab positions," he said. "First is an aging workforce, because older pathologists and lab directors are retiring, thus opening positions for younger colleagues.

"The second reason is that laboratories today have adjusted to the chilling effect on jobs and salary increases in pathology that resulted from successive cuts in Medicare payment for Part B testing," commented Cornell.

"Reason number three is the growing economy," he continued. "The robust economy not only boosts salaries but also helps pathologists in another way. After 2008, a number of pathologists were unwilling to retire because they had lost so much value in their stock portfolios. So, rather than retire, they continued to work. Today, the rising stock market has lifted the value of stock portfolios retiring pathologists hold.

➤Nest Eggs Bounce Back

"Thus, older pathologists are retiring now because their nest eggs have come back," explained Cornell. "In turn, those retirements create demand specifically for employed pathologists—whether they are hospital-based or in fee-for-service groups. That's because the lab organizations that employed them need to replace the senior people who retired out of those practices."

"What plays a roll in driving up salaries are new diagnostic technologies, such as genetic and molecular tests. An increased number of these tests require hospitals and independent labs to hire specialized pathologists, PhDs, and medical directors," he added.

Will Move for Opportunity

"Another factor that helps drive up salaries paid by labs is that pathologists and clinical lab directors are unlike physicians in other specialties who have to build up a patient base and so often cannot move easily," Cornell continued. "Conversely, pathologists can and do move freely within the healthcare system and thus can pursue higher-paying positions in a wide variety of cities and towns.

"Recently, I gave a presentation on a study we did of 344 pathology openings to find out who is hiring," Cornell said. "Of those 344 openings, 47% were academic positions, 27% were hospital based, 20% were in private labs, and 4% were in large commercial labs such as **LabCorp**, **Quest Diagnostics**, or **Sonic Health**.

"Next, we analyzed the posted job openings for the subspecialists these organizations wanted to hire," he stated. "It should be no surprise that the top opening in pathology was for a specialist in molecular testing. At the moment, the hottest subspecialty is broadly defined as molecular genetic pathology. That will be the case for many years.

"The number two most-sought-after subspecialty is hematopathology," added Cornell. "For the past two years, we've seen demand for hempaths rising right along with molecular.

"In fact, a large number of organizations are looking for molecular hematopathologists," he commented. "Hematopathology goes in hand with molecular testing. It's unclear, however, whether that linkage will continue, but strong demand for molecular specialists surely will continue.

Why do Younger Pathologists Decide to Change Jobs?

ARE NEWLY-HIRED PATHOLOGISTS looking for utopia on the job? Maybe, said Rich Cornell, of Santé Consulting LLC, a healthcare search firm.

"In their first five years on the job, about 40% of pathologists and maybe more, change jobs," Cornell said. "At our firm, we wanted to know why. We did a survey and determined that when they end their training, many pathology residents or fellows get into a job they weren't expecting.

"The reason for that is — right out of school—most residents and fellows choose their first jobs based on geography," he said. "Basically, they have tunnel vision because they're looking for a job in a specific location. Therefore, they take whatever comes along.

"But then, within two to five years, they find the practice wasn't exactly what they expected, they weren't made partner or were treated poorly," he said. "Maybe they don't like the workflow because they have to push out too many cases.

"So, for their second and successive jobs, they broaden their scope," he added. "Now compensation is secondary to other issues such as an improved quality of life. That may mean they want to work well with other pathologists in the group. They look at the demeanor of the practice and how the other pathologists approach cases.

"At this stage, I always tell them, utopia doesn't exist, but still that's what they want," observed Cornell.

"When demand for specialists rises, then the salaries for these clinicians rises too," noted Cornell. "That demand is why compensation for molecular pathologists and hematopathologists has risen over the past five years.

"In 2012, a fellow starting out in hematopathology would earn somewhere

in the range of $175,000 to $180,000 in annual salary," he said. "Today that same fellow would start at about $200,000 to $225,000 range.

"Mid-career pathologists are earning in a range from $270,000 to a high of $350,000," added Cornell. "Salaries also are rising at the upper end of the scale for more experienced pathologists—but not at the same rate of increase. A director or chief at a community hospital-based practice would have a salary today that's in the mid-$300,000 to the low $400,000 range.

"All of these salaries continue to rise from their levels following the Great Recession and from where they were just three or four years ago when there was a big hit to what Medicare paid for the Part B component," Cornell explained. "Those fee cuts really halted the market in terms of compensation. Every lab had hiring and salary freezes, and starting salaries were very conservative. But now we see a market adjustment.

A Market Adjustment

"That market adjustment shows how pathology is changing," he said. "Today, as senior people retire, hospitals bring in pathologists who are younger and are savvy about the technology in use today. By that I mean the testing technology for genetic and molecular assays, next-generation sequencing, and whole exome sequencing.

"These younger pathologists have experience of 10 or more years and they have a vision of where pathology is going," explained Cornell. "They can help the hospitals or pathology groups that hire them to move to the next phase of where diagnostic medicine is headed.

"One example illustrates this aspect of the demand for pathology expertise," he noted. "Recently, I received a call from a community hospital-based pathology practice. This practice served a 220-bed, physician-owned hospital. The hospital CEO is a physician who understands where precision medicine is going. The CEO called the director of pathology to say the hospital needed to hire a molecular pathologist.

"That CEO saw what was happening in healthcare today and recognized where cancer treatment is headed," continued Cornell. "Cancer treatment is becoming more focused on molecular testing and so the CEO suggested that this hospital hire a molecular pathologist so that it could establish a molecular program to allow them to compete effectively today and be well positioned into the future.

"Will this be a broad market trend?" he asked. "It's a bit early to tell. Meanwhile, we continue to get calls to fill positions like the example above. This is why I predict that smaller hospital systems will want to bring on molecular testing in the coming years," Cornell concluded. "That may be where this is headed." TDR

—Joseph Burns

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Survey of Pathologist Salaries Indicates Stability during 2015

EACH YEAR, A SURVEY OF PHYSICIAN SALARIES is published by *Modern Healthcare*. Below is the data it published in December 2016, about pathologist salaries for 2015, as reported by seven organizations.

		% change 2014-15
HHCS	$368,284	28.4%
AMGA	$363,636	2.4%
Sullivan	$355,559	0.2%
MGMA	$342,552	-5.6%
ECG	$337,050	-3.2%
Compdata	$275,300	3.7%
Pinnacle	$211,000	0.5%

KEY: American Medical Group Association, Compdata Surveys & Consulting, ECG Management Consultants, Hospital & Healthcare Compensation Service, Medical Group Management Association, Pinnacle Health Group.

INTELLIGENCE

LATE & LATENT

Items too late to print, too early to report

Theranos, Inc., was in the news again recently. On Feb. 16, *The Wall Street Journal* reported that Theranos had just $200 million in cash. The information came from a conference call the discredited lab testing company conducted with its investors. During the call, Theranos officials also stated that the company had no material revenue during 2015 and 2016. Another interesting fact that emerged is that the company has not put cash into reserve against potential liabilities from the lawsuits that have been filed against it by customers, investors, and others. For example, **Walgreens**, its former partner, is suing Theranos for $140 million.

MORE ON: *Theranos*

The Journal also reported last month that, following CLIA inspection of the Theranos lab in Scottsdale, Ariz., the company had received a letter on Jan. 16, 2016, from Medicare officials listing "condition level failures and immediate jeopardy." The company had not disclosed that fact until recently. Other news sources reported that the number of employees at Theranos has shrunk from 700 to about 220 currently. The company says it continues to work on developing its miniLab testing instrument. That product was unveiled at last summer's meeting of the **American Association of Clinical Chemistry** and was met with much scepticism.

ELLKAY ACQUIRES CAREEVOLVE

Last week, **Ellkay, LLC**, of Miami, Fla., completed its acquisition of **CareEvolve**, a division of **Bio-Reference Laboratories, Inc.** CareEvolve provides labs with an integrated lab order/lab resulting portal, among other services. EllKay, founded in 1999, offers healthcare providers interconnectivity and data migration services.

TRANSITIONS

• Rina Wolf has retired as **XIFIN, Inc.'s** full-time Vice President of Strategic Commercialization, Consulting, and Industry Affairs. She will continue to do some consulting work for XIFIN and has accepted a faculty associate position at the **ASU International Graduate Program**.

• **MolecularMD** of San Diego, announced the appointment of Fritz Eibel as Senior Vice President and Chief Marketing Officer. Eibel has previously worked for **Wren Laboratories**, **RainDance Technologies**, **Agena Bioscience**, **Life Technologies**, **Gen-Probe**, and **Roche Diagnostics**.

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 growing shortage lab scientists in the United Kingdom. Pathologists and physicians are warning the **National Health Service** that delays in lab testing are imminent because of inadequate numbers of trained lab professionals.

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, March 13, 2017.

SPECIAL SESSION!

Essential Insights for All Anatomic Pathology Groups!

Charles Merritt
CEO, Pathology & Cytology Labs, Inc.

How Our Pathology Group Built Market Share and Protected Pathologists' Incomes Even as Payers Cut Prices

If your lab or pathology group wants to protect and enhance revenue and pathologist income, then this is the must-attend session for you! Charles Merritt will share the clinical strategies and business tactics that he and the 11 pathologists at Pathology & Cytology Labs, in Lexington, Ky., use to boost revenue and sustain profit margins.

You'll learn common-sense ways to deliver value to physicians and payers that make a difference. Best of all, these are approaches that will be easy for you to take back and use with your pathology group.

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- ***Lab Industry Fears Grow as Medicare Officials Prepare to Implement Deep Medicare Part B Fee Cuts.***
- ***Why UnitedHealthcare Is Suing Labs in Texas for $100 Million, Will There Be More Lawsuits?***
- ***How Hospital Labs Are Delivering Value by Serving Anti-Microbial Stewardship Programs.***