



SPECIAL REPORT

# **The Counter-Argument to Selling Your Hospital Lab:** The Pitfalls, Risks, and Hidden Costs Associated with Selling or Outsourcing Your Hospital Clinical Lab







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## The Counter-Argument to Selling Your Hospital Lab: The Pitfalls, Risks, and Hidden Costs Associated with Selling or Outsourcing Your Hospital Clinical Lab

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# Introduction

The state of the US lab industry is one of significant disarray. What with insurance companies' exclusive contract arrangements, lab benefit management contractors disallowing local hospital competition, the FDA's proposed rules on LDTs, CMS's reductions to the Clinical Lab Fee Schedule, thousands of unproven genetic tests flooding the market, and exclusive State Medicaid contracts, it is hard for hospitals to know if being in the lab business is still a worthwhile endeavor.

This is further complicated by the fact that health systems now control upwards of two-thirds of all physician practices, and along with that ownership comes all the physician office lab testing (Lab Outreach).

In a recent article published by the Clinical Laboratory Management Association (CLMA), Suzanne Carasso described Laboratory Outreach in the US as "big business." Of course she is correct with lab outreach testing representing approximately "one-fifth of the total lab industry" and "on average, a hospital-based outreach program generates \$24.9 million in annual revenue and a 23.5% contribution margin [Avg CM = ~\$5.9 million]." Ms. Carasso summarized the situation hospitals find themselves in with respect to their labs as follows:

"Increasingly, health organizations are asking three key questions:

1. Should we outsource or sell part or all of our laboratory services before reimbursement drops?
2. Does partnership or joint venture with a commercial laboratory make more sense economically?
3. Do we want to maintain ownership and control of our laboratory services?"

This white paper will attempt to delve deeper into these questions with the hopes of provoking meaningful discussion by highlighting some of the pitfalls and hidden costs that may be associated with the sale to a commercial lab.



# Part 1

## The True Value of Your Hospital Clinical Lab

Since 2013 when the sale of UMass Memorial Health Care (UMMHC) lab network to Quest Diagnostics first made national news, national lab companies have been pursuing acquisitions of hospital laboratory assets at fever pitch and for good reason. But is a sale really in the best interest of the hospital, its patients and its community?

Lab spending only represents four percent of total healthcare spending in the USA.

### A Case Study

In the case of the UMMHC purchase, Dr. Eric Dickson, CEO of UMass commented that because of pricing pressures he no longer viewed hospital-based lab ventures to be profitable, hence his decision to sell the lab network (Eckelbecker).

In reality, UMMHC was bleeding financially and in spite of vast and concerted efforts to reduce costs, through both internal resources and the assistance of outside consultants, the magnitude of the expected losses was insurmountable. It would take the next three years or more for UMMHC to cut costs sufficiently to offset reductions in revenue. The proceeds from the sale served to temporarily mask the financial difficulties and likely saved a few of the top executive jobs.

In January 2014, a local Boston news outlet published an article stating "*...if not for a one-time gain of \$108 million from the sale of certain lab operations, the system would have ended its fiscal year in negative territory...*" (Eckelbecker 1).

Based upon publicly available financial statements, UMMHC would have reported a \$55 million loss in 2013 and would have had less than \$40 million in cash on hand. UMMHC continued to struggle, reporting another loss in 2015 of \$7.9 million. Moody's Investor Services even downgraded UMMHC's rating "to one step above 'junk' status" (Eckelbecker 2).

At the time of the sale, the public was not privy to the internal forecasts and the statement by the CEO was obviously one that did not draw attention to the underlying problem. The danger with this is that it may have led others to follow suit or, at a minimum, contribute to a false narrative regarding Dickson's statement.

In the case of UMMHC, the sale gave this health system the appearance of financial well-being. The financial health of community hospitals at large, regardless of size, is important for a number of reasons, including: workforce stability, patient confidence, and physician recruitment, to name a few. But, is masking a problem the responsible thing to do?

What is the value of the hospital clinical lab and does it deserve a fair evaluation before selling to the highest bidder?

### Hospital Labs Overlooked and Undervalued

Historically, the hospital lab is a department that has often been overlooked by hospital administration. Some have relegated it to a position of just another cost center and

others a commodity, like laundry and linen services. One of the reasons is that since the 1980s hospitals have been paid based upon Diagnosis-Related Group (DRG). Fees paid to hospitals and clinical labs have been under attack by CMS and third-party insurance companies. This is nothing new; in fact, this has been the case for the past three decades. However, lab spending only represents four percent of total healthcare spending in the USA.

## Taking a New Look

Today, government mandates under the ACA's new payment models provide an opportunity for hospitals to treat the lab as a revenue center. Value-based metrics have led a number of innovative health systems, such as Vanderbilt, Mayo, Cleveland Clinic, Johns Hopkins, and Columbia University Medical Center to take a deep dive into the area of lab science and the relationship between test results and medical decision-making (Johnson et al). Lab science plays a vital role in the continuum of care, from physician office to the ER, surgery, ICU, PICU, and so on. As more health systems invest in population health strategies and measures programs prescribed by MACRA and MIPS, the value of the hospital lab is more transparent.

In a recent HFMA article (Winter 2017), Henry Ford's J. Mark Tuthill, MD said he believes *"laboratories can support the overall objectives to improve patient outcomes and reduce costs"*. 1). Hospital executives need to consider taking a fresh look at their laboratories before entering into any form of outsourcing arrangement. They need to consider how much their clinical care, outcomes management, and population health management departments rely on the lab.

Can an outsourced lab arrangement in a value-based care environment really provide the same high-level of touch to physicians and patients in areas of clinical decision-making and customer support as one would get from an internally managed department? Will independent labs, many notorious for poor customer service for non-rapid, routine testing, be able to perform at an optimal level in a hospital setting where they will be responsible for chronically ill inpatients? Will they collaborate with physicians in the same manner to reduce test utilization and help physicians redesign care algorithms?

Reportedly, there are 1,000+ hospitals with outreach programs (Paxton). These and others have realized the significant role labs play in care management. As such, and in support of clinical strategic initiatives aimed at value-based contracting, many have begun to invest in lab database decision support systems (e.g., Visiun and Viewics). Still others who had previously sold their labs are now pulling those lab operations back under hospital ownership. At least two of the health systems that were part of the original founding members of Spectrum Laboratory Network (most recently sold to Quest Diagnostics under the name Solstas Labs) in Greensboro, NC have taken their operations back, canceling their outsourced contracts.

## Lab Business Economics and Alternative Lab Models

Most of the hospital lab acquisitions are a result of the independent labs attempting to regain their physician office market share, as this had been eroding in recent years. Together, the acquisition of physician practices and the aforementioned 1,000+ outreach programs took a sizable amount of market share away from the national labs.

Given the investment every hospital has in their laboratory, it only makes sense to bring as much volume into the lab as possible, taking advantage of the economies of scale.

By its very nature, laboratory medicine is a high fixed cost, low variable cost business. The real investment is in the upfront cost of instruments, software, space, and people resources. The incremental, variable cost of running tests (reagents and supplies) is fairly small. Adding volume in this type of business lowers the fixed-cost component for every test performed. Hence, insourcing tests from physician practices actually decreases the cost of individual tests performed for inpatients and outpatients alike. Given the investment every hospital has in their laboratory, it only makes sense to bring as much volume into the lab as possible, taking advantage of the economies of scale. Further, for every test that is performed in-house there is one less test sent to a reference lab, thereby lowering the expense on the physician practice P&L (Hiltunen).

The national lab companies understand economies of scale and will represent to hospital administrators that their cost per test is much lower than most hospital's. Is that really the case? If it is true, how is it that reference lab pricing isn't significantly lower than it is? If their variable cost is so low, why is it they price the tests performed for smaller hospitals at a higher price than they price the tests performed for larger hospitals? While the national labs may have the ability to purchase supplies at a price most hospital labs cannot, they also have a huge SG&A burden, including the cost to operate a fleet of airplanes, costs related to being publicly-traded, multi-million dollar executive salaries, and the payment of dividends to their shareholders.

One thing to keep in mind is it takes a considerable amount of volume to impact any one of the national labs' financial statements. While every test is accretive to earnings, deals that leverage existing infrastructure and limit transportation costs are the most accretive of all. This is one of the reasons we have seen most of these acquisitions in close proximity to the national labs' large metropolitan locations. Take the Mount Sinai lab acquisition (announced February 2017); there is a LabCorp facility across the river in NJ. Proximity, however, will not be an advantage for them in every situation. For geographically diverse hospitals, what kind of support will one's inpatient lab get when there is a problem?

### **Hospital Downstream Revenue**

The number of physician practices acquired by health systems over the past 10 years and currently under hospital ownership has grown from roughly 22 percent to upwards of 66 percent. The rationale behind most of these acquisitions by health systems was the benefit of downstream revenue. Yet, it has been widely reported that hospital physician practices are losing, on average, between \$100,000 and \$200,000 per year, per physician (Zimlich 1). While 1,000+ hospitals have robust lab outreach programs, there are an estimated 80 percent of the remaining hospitals that do some outreach but could do more (quoted in Paxton). This means that lab orders generated by the practice physicians are going to another lab, not the hospital's lab. With downstream revenue being the premise, shouldn't lab testing be considered a part of that opportunity? Why do hospitals allow this kind of leakage?

Financially, some practices already capture the revenue, but they are incurring costly reference lab bills in the process; others do not even attempt to capture the revenue. The

average physician in private practice can generate between \$50,000 and \$100,000 per year in net collectible revenue from lab testing and specialty practices like immunologists and pain management doctors can generate upwards of \$1.0 million per physician per year. Isn't it worth every hospital C-suite's time to investigate what incremental margin is possible?

For those who have not yet insourced their physician office lab testing into their hospital labs, Kathy Murphy, CEO of Chi Solutions, asks the question, *"What other department can a hospital CEO open to business outside the hospital facility and immediately add revenue and accrete profit?"* To establish a viable lab business servicing physician offices one needs a referral base, IT systems, a trained workforce, certification / accreditation, licensure, transportation for specimens, compliance, oversight, and billing. All of these already exist in most hospital labs.

### **Collaboration, Consolidation, Joint Venture, and Other Operating Models**

Of the 1,000+ hospital outreach lab programs that already exist, there are a variety of operating structures. In addition to single hospital outreach programs, a number of joint venture and regional collaborative models can be found. There are many for-profit hospital-based lab ventures where either a multi-hospital system or several hospitals have partnered together to form a joint venture service organization (Malone). On the high-end, some of these have achieved net revenues from physician office testing in the range of \$50 million to \$100 million (Shinkman). A *"successful hospital laboratory outreach [program] can furnish more than half of a hospital's pre-tax earnings while accounting for less than 10 percent of its overall costs"* (Shinkman).

Health systems like the University of Pennsylvania, Barnes-Jewish Hospital, and St. Louis Children's Hospital are consolidating operations, establishing core labs to take advantage of the economies of scale (AHA- H&HN report 8-9). North Shore Long Island Health System is another example of an extensive outreach network (Bossuyt, Verweire, Blanckaert). Kathy Murphy, whose company surveys hospital labs annually concludes, *"There is no reason a hospital lab cannot be competitive in this market from a service standpoint, a pricing standpoint and a profitability standpoint"* (quoted in Paxton).

Hospitals have a number of other opportunities to lower reagent and supply costs. Take, for example, BJC Healthcare collaborative in Missouri and Illinois. In this case, 35 hospitals from different health systems joined together, establishing a regional purchasing cooperative. With this, they combine their purchasing power to negotiate lower prices on contracts for reagents, supplies, and outside services. In addition, they use each other as reference labs in instances where they have particular expertise in specialty testing areas (Aston 8). For example, why should two hospitals in the same town both have microbiology or molecular biology testing when they could share the cost and have one service both entities.

In these instances, the hospitals retain control and lower their respective costs; they keep quality at the level necessary for inpatients and improve their systems' bottom lines. They cut the middle man out of the equation and utilize the national labs to performing only low volume esoteric reference tests.

While healthcare reform under the new administration is underway, adding to uncertainty, not unlike previous years, Anne Paxton of CAP TODAY previously noted, "...experts and laboratory executives in the outreach diagnostics sector are anything but pessimistic about its prospects. Not only do these observers see hospital outreach programs employing diverse strategies to expand their client base, broaden test menus, and reap healthy profits, they see many new players entering [the market]" (Paxton).

Pathologists and genetic counselors are helping to establish processes to determine the appropriate use of the more than 70,000 genetic tests available on the market today.

### Lab Scientists, the Physician Partners

Diagnostics plays a vital role in healthcare decision-making where an estimated 70 percent of clinical decisions are based on diagnostics and an estimated 80 percent+/- of all data in EMR systems is related to lab test results (Aston).

John Spinosa, MD, PhD, a pathologist and former Chief of Staff at Scripps Memorial Hospital, La Jolla, Calif., "agrees that laboratories can help align physicians and set the stage for clinical integration

efforts." Spinosa went on to say, "Of all the services that a health system provides, laboratory services are probably the one service that is in most physician offices... So the touch point of a laboratory is expansive for employed and independent physicians" (Bossuyt, Verweire, Blanckaert).

With pharmacogenetics now part of the diagnostic landscape, hospital labs are playing an ever-increasing role in helping physicians individualize patient care while insurance companies are looking for more evidence-based data to determine the efficacy and efficiency of new therapies. Lab scientists are being consulted to help clinicians design and fine-tune care maps and treatment algorithms across every line of service whether it be inpatient, outpatient, or in a physician's office. "From early detection and diagnosis of disease to individualized treatment plans based upon a person's unique genetic makeup, clinical lab testing is key to improving healthcare quality and containing long-term health costs" (quoted in ARUP).

Doctors need laboratorians to tell them which tests are beneficial and which ones are not. Paramount to this process is making sure the right test is performed at the right time, in the right sequence, and on the right patients.

Lab personnel are helping clinicians identify patients in need of closer disease management and those who may be at future risk (prognostic medicine). Pathologists and genetic counselors are helping to establish processes to determine the appropriate use of the more than 70,000 genetic tests available on the market today. Interpreting results from these genetic tests and determining how that information is used is useful in improving patient outcomes.

At Henry Ford, a task force of clinical leaders "from all departments, spearheaded by pathology and laboratory medicine, is responsible for exploring precision diagnostics technology" in order to guide future decisions on precision medicine and guide physicians to proper utilization of lab tests. This is done to improve outcomes, reduce complications, lower costs, enhance population health strategies, and ultimately drive physician alignment and clinical integration (Bossuyt, Verweire, Blanckaert).

At the University of California San Francisco Medical Center, “neurosurgery residents targeted overutilization in the laboratory and reported a \$2.0 million savings after cutting five laboratory tests in half without affecting patient outcomes” (Herriman 1).

According to a research report by IBISWorld,

*“... [Labs] are an integral part of patients' medical evaluation and treatment. Laboratories are vital to the healthcare sector due to industry operators providing healthcare practitioners with information concerning the onset, severity and cause of patients' ailments and illnesses. Furthermore, the aging population and the movement toward preventive care have stimulated demand for industry services.”*

The report went on to say, labs already performing tests for physician practices should be viewed by their C-suite as

*“a platform for supporting resource allocation by building sustainable revenue streams and enhancing relationships with community physicians. Outreach laboratory services not only maximize hospital revenue, but also can work as a bridge to strengthen between the hospital and the community. These relationships are vital as strategic assets, and, as the demands on physicians continue to multiply, they will increasingly rely on their laboratory partners for support”.*

## Better Data for Better Decisions

Electronic medical record systems, improved connectivity, and data integration have spurred a new line of decision support tools enabling analysts to drill into lab data, providing a business picture of the lab that has rarely been available until now. Dr. Sean Palfrey wrote, “I believe we must rediscover the value of clinical judgment and relearn the importance of the personal, intellectual, scientific and administrative thought that is central to the best practice of medicine” (Palfrey).

When in cost-reduction mode, the natural thing for most hospitals and consultants to do is to attempt to address cost containment from a supply-chain perspective. While supply-chain solutions have their place, the best way to approach cost containment in a lab is through a combined insourcing and test utilization approach (Aston).

With support from lab administration, lab directors need to proactively work to become ‘CEOs’. This is in and of itself a challenge because most lab directors have no training in areas of finance, sales, or marketing. Yet, it is no longer acceptable to just know how to run a set of instruments and submit employee performance evaluations to personnel.

Today lab directors must know the vital operating statistics that drive profit (Herriman). Adopting tools like Visiun's Performance Insight, which drills into utilization data, is a great way to start.

## Top Down Support, Seller Beware

Hospital CFOs can help lab directors by assigning a financial analyst to help pull information from billing and financial systems and to help design financial statements that demonstrate the true profitability of the lab's operations. All too often, lab directors are only given gross revenues. Instead, what is needed is net revenues by billing mix (Shinkman). Arbitrary allocations of hospital-wide costs make their way into lab financial statements

and supply invoices get expensed when processed rather than matched to consumption. Employee labor is often not reflective of actual lab staffing and too few cost centers are assigned to the lab. These issues prevent the hospital from properly segregating and analyzing lab costs and productivity.

Hospital administrators need to understand that different sections in the lab have differing labor productivity metrics. In fact, many sections in a lab are by nature still very manual. How manual depends upon the technology employed. One labor metric does not apply to every section in the lab. Each section needs to be looked at separately. Pathology, cytology, microbiology, registration, customer service, and phlebotomy can range from manual to semi-automated processes. Hematology, chemistry, immunochemistry, and urinalysis are mostly automated. There are also varying levels of automation, including systems that auto sort and route tubes, auto-aliquot specimens, centrifuge, store, and retrieve specimens. These areas should have much higher labor productivity metrics.

As complex as lab science is, it is equally important to understand the nuances of the business around the lab and have financial reports that properly reflect the financial contribution to the hospital's overall results. The national labs are counting on hospitals to not have this data and for the seller to be under-informed.

## **Pricing & Billing**

Hospitals that decide to insource the testing from physician offices need to be nimble and realize physician office testing must be billed differently than inpatient and outpatients. This means that registration systems need to accommodate a third patient type and either separate billing software should be used, the physicians' billing system should be used, or an outside service provider should be used.

Another decision hospitals need to make in a very pragmatic way relates to their pricing of physician office testing. Even though third-party insurance contracts may allow them to bill physician office tests at outpatient rates, the right thing to do is to establish a separate fee schedule that is more in line and competitive with that of other independent labs operating in the state. If a hospital doesn't, it is opening itself up to patient complaints. Other labs will use this as a weapon against the hospital with the insurance companies and the physician community (Shinkman).

The national labs, having created exclusive contracts with a number of third party insurers and state Medicaid offices, are already employing a number of tactics to take market share away from hospitals with outreach services. The right way to approach this is to leverage the hospital's contracts but also be fair and competitive.

Offering physicians 'hospital quality testing at commercial rates' is a winning strategy—for the hospital, the physician, the patient, and the insurance company.



## Part 2

# The Argument Against Selling Your Lab

### Assessing Pitfalls, Risks, and Hidden Costs

Hospital lab operations affect almost every other aspect of hospital operations and patient care. With offers frequently being presented to hospital C-suites, it is time for those in charge to take the appropriate time to evaluate these offers with a number of questions in mind. For example, will the lab partner interact with the clinical care teams daily and in meaningful ways? Whose best interest will be represented, the hospital where test utilization management is paramount or the contractor who now has to absorb additional overhead and to whose benefit it is to leverage its national facilities?

Should problems arise, how many problems will one endure before a course correction is made? What damage will have occurred in the meantime? What will it cost to re-enter the lab business should the hospital look to take it back over? How much of a disruption will that mean for the departments that rely on the lab to operate at consistently high standards? What will the effect be on employee retention? On physician and patient satisfaction?

In her article entitled, *"Hidden Errors A Watchdog Report – Weak oversight allows lab failures to put patients at risk"*, Ellen Gabler details out a number of errors that led to lawsuits for a couple of the national labs, from missed HIV diagnosis to pre-natal screening errors, to incorrect paternity test results, to errors in simple employment drug screens. In the article she states her investigation *"identified problems in laboratories that are systemic and the result of attempts to cut costs and save money."* Sharon Ehrmeyer, research participant and professor of pathology and laboratory medicine at the University of Wisconsin School of Medicine and Public Health, stated, *"We have every right to assume that our safety, our health, is not being compromised by something stupid"* (Gabler). Jason Jarzembowski, director of the lab at Children's Hospital of Wisconsin said, *"The risks are too great for inferior lab work to be tolerated. The question isn't, 'How much do you save by cutting corners? The question is, 'How much would you lose if you got something wrong?'"* (Gabler).

Richard Peisch (Harvard Business Review) in his article, *When Outsourcing Goes Awry*, noted, *"Moving work out of an organization should always be undertaken with a great deal of deliberation."* Writing about one hospital CEO's ill-fated outsourcing of anesthesiology, *"[the CEO] chose to outsource a critical component of his business with little awareness of the real issues involved."* Peisch interviewed the then CEO of George Washington University, Tom Chapman, who commented, *"[The hospital CEO] did not clearly understand the problem, how did he think he could solve it with an outsourcing arrangement?"* Adding, *"The hospital should have acted on its duty to protect the patients, the public and the medical staff – as well as its own business. That basic responsibility to the community is paramount; anything less would be bad business strategy"* (Peisch).



## Part 3

### Factors to Carefully Consider

The following items are provided to help with the evaluation and construction of a cost effectiveness analysis related to selling or outsourcing your hospital lab:

**Consider the potential for delays and failures that could impact other departments, such as pharmacy, nursing, and EVS.**

- What is the cost of an adverse impact on length of stay?

**Consider the impact a loss of control could have.**

- On lab staffing, test menus, and the interplay between the lab and physicians.
- Should the contracting lab change instruments, who will provide the resources to affect the change?
- What will the impact be on other hospital departments, such as IT, radiology, oncology, and dialysis?
- Who gets a voice and who makes the final decision on what is right for the hospital?

**Shifting test location is one way the contracting lab will try to save money. Delay will not be an effective argument to keep a test on the menu. In an outsourced arrangement, there will be little negotiation on test mix.**

- What happens to service delivery if certain tests are taken offsite that other departments rely upon on a STAT basis?
- What happens when physicians become dissatisfied with the modified in-house test menu and complain to administration?
- Will lab employees be caught in the middle between the medical request and the business decision?

**Consider a failure to run the right test at the right time or the failure to deliver test results accurately.**

- It is not uncommon for the contracting lab to substitute methodologies to one that may be less expensive and likely not the *gold standard* choice of hospital physicians, e.g., syphilis, PSA, TB, or Hgb A1C.

**What is the potential for incurring significant additional non-reimbursable costs?**

- Studies from other industries have shown that outsourcing arrangement can cost as much as 65 percent more than the face value of a contract ("The Real Cost of Outsourcing"). There is cost associated with vendor selection, transition, layoffs, ramp-up, culture impacts to productivity, and the cost to manage the contract once signed.

**Consider the impact expert execution in the lab can contribute to significant cost avoidance.**

- Who is most likely to deliver that kind of performance and under whose watchful eye?
- Contract labs will look to cut more labor to reduce costs. This may be on nights and weekends outside the watchful eyes of daytime administration.
- What happens when a 3 a.m. trauma case needs blood and no one is there to answer the page?

**What if there is a loss of oversight and management in the lab?**

- How will this affect the lab's licensing and accreditation?
- Test quality and accreditation are not effortless things that happen on their own. It takes diligence. Lab result values and reference lab values have to correlate; they have to be monitored and published. No difference is too small.

**Consider the interplay and potential conflicts between and with differing organizational behaviors, benefits and work ethic.**

- Where will employee loyalty lie? With the hospital or the contract lab?

**Consider the impact of reduced onsite test menus and an increase in specimen travel.**

- Consider specimen control as an issue—i.e., every specimen handoff is an opportunity for an error to occur, the most egregious being a lost specimen.

**Consider the impact of potential patient dissatisfaction.**

- Patients complain to their doctors, the doctors complain to administration which then relies on the contract lab to solve the problem.
- How much control over patient satisfaction are you willing to give up?
- Look up online complaint logs to see what patients are saying about the prospective lab contractor. How will members of your community respond, as they too have access to these reviews?

**What will happen to patient draw centers and phlebotomists in physician offices?**

- Will draw centers close and require patients to go to the contract lab sites or will the contract lab close their locations and let the hospital foot the bill for non-hospital patients using the hospital draw centers?

**What about the financial impact of cost creep and add-on costs?**

- It's not uncommon for physician demand to change but this should not necessarily result in a profit enhancing opportunity for the contractor, whether it is the need for onsite lithium testing or a change in the drug screen profile

**What are the potential implications for the pathologist and pathology staff?**

- Consider from an accreditation perspective, the pathologist is the party responsible for all the machinations of a laboratory: tests, performance times, staff levels, quality control, environmental safety, and the choice of the reference lab. If purchased, there is no influence by a pathologist and once he or she realizes this, what happens then?

**Consider conflicts with billing. Who will be doing the billing and for which patients? How is that process going to be communicated and monitored? Consider the ramifications of inappropriate billing.**

- When patients complain to their doctors, the doctors will soon figure out that the lab employees have no control, so these complaints will end up in the administration suite.

**Where is the collaboration going to come from in terms of value-based care, test utilization management, and care algorithms?**

- Whose interest will be served, the hospital or the contract lab which benefits from increased volume?

11. 42 CFR 411.355(b)(1), (b)(2)

**Consider potential issues related to physician alignment and physician satisfaction/dissatisfaction.**

- If hospital staff is not satisfied with the lab and they see an opportunity to bring testing closer to the patient via point of care tests or table top analyzers this will happen overnight regardless of controls that may be in place. Removing these will then be a source of conflict.

**What's the cost to cancel an outsourced lab contract? What would be the cost to re-enter the lab business buying new or replacement instruments and re-interfacing everything to the LIS/HIS and EMR? What will the labor cost be and where will this additional labor come from?**

- The potential is for every piece of instrumentation to have to be replaced or reacquired. Depending on the size of the operation, this could cost millions of dollars and would take hundreds of man hours.
  - A recent hospital took back its microbiology department (one of the first things to be moved) and it reportedly is costing an estimated \$950,000 in capital and the required hiring of 15 trained FTEs. Will those resources be there when the time comes or will the best and brightest already have jobs?
  - One chemistry analyzer alone can cost between \$400,000 and \$700,000.

**Consider the impact a relatively small investment in the laboratory could have in terms of providing data insights to clinicians and administration in your current setup.**

- An investment of \$30,000 or less could yield returns 10 times that year after year.

**Consider the incremental profits to be realized by properly servicing and managing physician office lab testing and proper utilization management of IP/OP and reference lab orders.**

- Routinely, hospitals have insourced physician office testing in the millions and tens of millions of dollars with contribution margins in excess of 20 percent and reduced inpatient cost per test by 20-30 percent at the same time.

**Consider the health systems that recently had sold and outsourced their labs and now are bringing them back in house. Ask yourself why?**

## **In Summary**

Hospitals that choose to tap into the vastness of clinical and billing data in order to analyze the episodes of care will enable themselves to begin to manage the Total Cost of Care in ways not previously considered.

Once hospital administrators and C-suites take a serious look at the real value of their laboratory operations and the connected nature/integration with population health and value-based contracting, they will realize it is no longer about tests or testing; it's about managing diseases.

# APPENDIX A

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# APPENDIX B

## About the Authors

**Jeffrey A Downs** is the Managing Director for Valley Street Lab Partners, a Clinical Lab consulting firm specializing in all areas of Hospital Laboratory management and Hospital Lab Outreach development. Jeff is an experienced C-suite officer with more than 20 years in laboratory operations and finance. Having participated in the development and growth of one of the most successful hospital-based lab outreach programs in the US, Jeff knows firsthand how to grow and manage a lab network. Jeff has participated in more than \$400 million in healthcare-related financial transactions, with experience in corporate start-ups, turnarounds, mergers, acquisitions, and divestitures. Since 2010, Jeff has become one of the most highly regarded consultants in laboratory management.

**Margaret McMinn** is Senior Director of Laboratory Consulting for Valley Street Partners. A highly successful former VP of Hospital-Lab Operations, Margaret has more than 30 years of laboratory experience. From bench to boardroom, Margaret is regarded as a cost and labor efficiency expert. Previous roles include VP of Hospital-Lab Operations for Spectrum Laboratory Network and Solstas Labs, where she oversaw the operations of hospital labs at four systems. In addition, Margaret is a blood bank expert and published author.



# APPENDIX C

## About G2 Intelligence

*Advancing the Business of Diagnostic Medicine*

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G2 Intelligence clients can expect relevant, meaningful and actionable findings on diagnostic industry markets, guidance on related regulatory changes, and the latest strategies on profitable lab operations. The organization strives to exceed client expectations and develop mutually beneficial relationships with industry groups and stakeholders.

G2 Intelligence is a division of Plain Language Media, LLLP, an international, multi-media, B2B, specialty information publishing company serving: diagnostic labs, medical office managers, law office managers, and licensing executives.

For more information on the products and services below, please visit [www.G2Intelligence.com](http://www.G2Intelligence.com), or contact Randy Cochran at 1-888-729-2315, or [randy@plainlanguagemedia.com](mailto:randy@plainlanguagemedia.com).

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# APPENDIX D

## About Valley Street Lab Partners

Valley Street Lab Partners is a laboratory management and consulting firm that helps hospitals and independent labs reduce expenses by 10%-25% so that they can improve patient care. Our unique blend of hospital-based and independent lab experience gives us an advantage over other firms. Our consultants have extensive clinical lab experience including C-suite and VP level backgrounds with over 100 years combined clinical lab experience. Dozens of health systems have trusted our team to bring about transformative change in their lab services. Our experience includes working with for-profit and not-for-profit labs, turnarounds, mergers, acquisitions, joint ventures and specialty labs such as anatomic pathology, toxicology, molecular and genetic testing services.

### Services offered through our staff and that of our partner collaborations include:

- Revenue Cycle Management
- Lab Contract Management
- Labor Productivity
- Patient Blood Management Programs
- Physician Office and Outreach Lab Development
- Test Utilization and Lab Data Analytics
- Molecular and Genetic Testing Platform Selection
- Interim Management
- Staff Recruiting ([www.LabRecruiters.com](http://www.LabRecruiters.com))
- Buying and Selling Labs
- Mergers and JVs
- Asset-based Financing
- Cloud-based CPOE and EMR Integration
- LIS and Instrument Selection

### Real results:

- 500 million in deal transactions
- Deployment and development of internet-based lab ordering / result reporting systems
- Designed and managed supply-chain functions
- Lead lab instrument platform selection teams
- Vendor contract negotiations
- Post-merger synergy efforts
- Corporate governance and compliance
- Core lab design and construction management

### Consulting services in the following areas:

- Electronic Payable Solutions
- Population Health/Disease Management Programs
- Test Utilization Analytic Analysis
- Transfusion Variability Analysis & Best Practice Education
- Physician Practice Management Solutions
- Healthcare IT Solutions
- Med/Surgical Consulting
- Whole House Labor Productivity Analysis
- Insurance Review
- Supply Chain Audits
- Laundry/Linen Consulting
- EVS Consulting
- Food/Nutrition Consulting
- Biomedical Engineering Consulting

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