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2016 Practice Leader Survey Report



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Overview

As a new survey fielded by the College of American Pathologists in 2016, the Practice Leader Survey is a primary source of basic data on pathology practices. The survey supplements the CAP Practices Characteristics (PC) Survey, most recently conducted in 2014. Whereas the PC Survey was fielded to individual pathologists, the PL Survey targeted practice leaders those in leadership or administrative roles with specific knowledge of the practice's financial, operational, and billing information. The survey was designed to elicit one—and only one response from each pathology practice in the United States.

The survey asked questions about practice demographics (including questions on practice structure, case volume, and staffing levels); case mix revenue sources (including questions on both AP and non-AP services); hiring and staffing; market and regulatory issues (including questions on participation in value-based payment models, problems with coverage and payment, and factors that are expected to affect their practice in the next few years). The survey was fielded from March 21, 2016, to April 13, 2016. In total, 2,097 practices were sent email invitations to participate; 245 practices (11.7%) completed the survey. These respondents represented pathology practices in 43 states, Puerto Rico, and the District of Columbia. For all purposes, except where noted, the survey interval ranged from January 1, 2015, through December 31, 2015.

This report is divided into six sections:

- Practice Demographics
- Services Provided by Pathology Practices
- Sources of Practice Cases and Revenues
- Practice Staffing
- The Pathologist Job Market
- Business, Regulatory, and Legislative Issues Affecting Pathology Practices

Practice Demographics

Practice Setting

Most of the surveyed practices provided the vast majority of their services in a hospital setting. Nearly half (48%) were in nonacademic hospitals/medical centers while 23% were in academic hospitals/medical centers. Among the other respondents, 15% provided the majority of their services in an independent laboratory (eg, a laboratory that provides technical and professional services outside a hospital, academic system, or clinic); 4% were in a central or main laboratory for a health care system or integrated delivery network, 3% were in a forensic laboratory or medical examiner's office, and 2% were in a government or military laboratory (Figure 1).

FIGURE 1: Setting where the practice provides a majority of its services (n=245)



Practice Ownership

About one-half of the practices that responded to the survey are pathologist owned. Of these, 66% were located in a nonacademic hospital/medical centers and 20% were located in independent laboratories. Only 6% of pathologist-owned practices were based in academic hospitals/medical centers.



When looking at practice ownership by the practice setting, the ownership structure varied. The majority of academic hospital/ medical centers practices were owned by hospital/corporate owners (79%). However, the nonacademic hospital/medical center practices were predominately pathologist-owned practices (68%). Independent laboratories were mostly pathologist-owned practices as well (Figure 2).

* "Other" includes central laboratories, forensic laboratories/medical examiners offices, government or military facilities, physician-office laboratories, blood centers, and certain nonclinical settings.

Practice Caseload

Using the number of surgical pathology specimens as a quantitative proxy for the business done by a practice, the survey asked how many such specimens were processed during 2015. Respondents represented a broad segment of small, medium, large, and very large caseloads (Table 1).

TABLE 1: Distribution of Practices, by Number of Surgical Pathology Specimens Processed in 2015 (n=229)

Number of Surgical Pathology Specimens Processed Annually	% of Practices
N/A	7%
Small (1–9,000)	34%
Medium (10,000-24,999)	24%
Large (25,000-49,999)	21%
Very Large (50,000+)	13%

Practice Size

Most (74%) practices reported having 10 or fewer full-time equivalent (FTE) pathologists. Over half of respondents (52%) were in practices with five or fewer full-time pathologists on staff (Figure 3).







* For the purposes of calculating the number of full-time equivalent pathologists, part-time pathologists are counted as 0.4 full-time pathologists.

Services Provided by Pathology Practices

AP and CP Services

Most pathology practices (85%) perform both anatomic pathology (AP) and clinical pathology (CP) services. About 11% of practices are AP only and 3% are CP only.

TABLE 2: Types of Services Provided by Pathology Practices, by Practice Setting						
Number of Surgical Pathology Specimens Annually Processed	AP only	CP only	Both AP and CP			
All (n=230)	11%	3%	85%			
Nonacademic hospitals/medical centers (n=116)	2%	0%	98%			
Academic hospitals/medical centers (n=54)	6%	4%	91%			
Independent Laboratories (n=34)	41%	12%	47%			
Other* (n=26)	27%	8%	65%			

* "Other" includes central laboratories, forensic laboratories/medical examiners offices, government or military facilities, physician office laboratories, blood centers, and certain nonclinical settings.

Practices in independent laboratories were the most likely to be AP only or CP only. Fewer than half of these practices provided both AP and CP services, and nearly as many (41%) were AP only. About 12% of practices based in independent laboratories were CP only (Table 2).

AP Technical Component

The AP technical component (TC) refers to payment for a pathology service that reflects the cost of equipment, supplies, technician salaries, and professional liability insurance. The share of practices that bill for the TC was far greater for laboratory-based practices than for hospital-based practices. Practices based in independent laboratories were far more likely than hospital-based practices to bill for TC. About two-thirds of independent laboratories bill for TC for a laboratory that the practice owns, and 17% bill for services purchased from another laboratory. Similarly, 38% of practices in "other" settings (primarily those based on central laboratories or government/military laboratories) bill for TC for services provided in their own laboratory, and 14% bill for services purchased from another laboratory. By contrast, well under half of hospital-based practices (whether academic or nonacademic) bill for TC, whether for services provided by their own laboratory or for services purchased from another laboratory. This is to be expected, since TC services provided by hospital-based practices are often covered under Medicare Part A payments made by the hospital to the practice (Figure 4).



Practices based in nonacademic hospitals/ medical centers that bill for TC sevices provided in their own laboratory



* "Other" includes central or main laboratories for health care systems or independent delivery networks; government or military laboratories, physician-office laboratories, and practices where pathologists serve as consultants. Practices based in forensic laboratories and medical examiners' offices are excluded.

Note: Some practices bill both for services provided by their own laboratory and for services purchased from another laboratory.

Molecular Test Interpretations

The survey asked respondents whether pathologists in their practice perform interpretations of molecular tests, such as pharmacogenomics, FISH, NGS, or PCR (excluding immunohistochemistry test interpretations). Nearly half (48%) of the practices responded that they performed molecular test interpretations in 2015. Practices based in academic hospitals/medical centers were most likely to perform molecular test interpretations, while those based in nonacademic hospitals/medical centers were least likely, with only one-third of such practices performing this service (Table 3; Figure 5).

TABLE 3: Percent of Practices Performing Interpretations of Molecular Tests by Practice Setting

	% of Practices
All (n=230)	48%
Academic Hospital/Medical Center (n=54)	83%
Nonacademic Hospital/Medical Center (n=116)	33%
Independent Laboratory (n=34)	50%
Other* (n=26)	38%

* "Other" includes central laboratories, forensic laboratories/ medical examiners offices, government or military facilities, physician office laboratories, blood centers, and certain nonclinical settings.





Most practices were experiencing growth in the volume of molecular test interpretations that they were performing. One-half of practices that performed such tests saw growth of more than 10% between 2014 and 2015, and another 29% saw growth between 1% and 10%. Academic hospitals/medical centers and independent laboratories were most likely to have experienced substantial growth (>10%), while nearly one-half of nonacademic hospitals/medical centers experienced growth of up to 10% (Figure 6).

FIGURE 6: Change in Volume of Molecular Test Interpretations Performed By Practice Setting, 2014-2015



Sources of Practice Cases and Revenues

To better understand differences in the economics of pathology practices, respondents were asked to identify the sources of their caseloads and revenues. For caseloads, the survey asked them to identify the source of AP specimens that pathologists in their practice received and signed out in 2015. Practices also identified how different kinds of services contributed to their revenue, the settings that accounted for their cases, and for the sources of payments received.

Respondents rated the level of confidence they had in their responses to these questions. There were five choices: "extremely confident," "very confident," "somewhat confident," "less confident," and "not confident." The tables in this section reflect those respondents who reported that they were "extremely confident" or "very confident" in their responses. These responses accounted for 48%–58% of total responses for the questions and were generally representative of the overall totals.

FIGURE 7: Largest Source of Practice Revenues by Type of Service (n=225)



Sources of AP Specimens

Surgical pathology was the largest source of revenues for 78% of respondents (Figure 7). On average, about 62% of practices' AP specimens came from hospital inpatients or outpatients, while 26% came from nonhospital sources such as outreach and physician offices (Table 4). The sources of AP specimens varied by practice setting. Inpatient and outpatient hospital care was the source for 74%–80% of AP specimens for both academic and nonacademic hospitals, but less than 25% of AP specimens for independent laboratories. On average, 58% of AP specimens for independent laboratories came from nonhospital sources.



Surgical pathology cited as the largest source of practice revenues for responding praactices.

TABLE 4: Average Source of AP Specimens Among Respondents Who Were "Extremely Confident" or "Very Confident" in Their Responses, by Practice Setting

	Hospital: Inpatient	Hospital: Outpatient	Non-hospital (eg, outreach; physician office)	Pathology consults (from different institutions)	Other Source	Unsure
All (n=123)	31%	31%	26%	3%	8%	2%
Academic Hospital/Medical Center (n=27)	36%	38%	18%	4%	1%	4%
Nonacademic Hospital/ Medical Center (n=59)	42%	37%	19%	2%	1%	0%
Independent Laboratory (n=22)	11%	13%	58%	4%	14%	0%
Other* (n=15)	13%	19%	20%	1%	40%	7%

* "Other" includes central laboratories, forensic laboratories/medical examiners offices, government or military facilities, physician-office laboratories, blood centers, and certain nonclinical settings.

Totals may not sum to 100% due to rounding.

Few differences emerge when examining the source of AP specimens by practice size (measured as number of AP specimens processed and signed out in 2015). On average, hospital inpatients accounted for slightly over 30% of specimens regardless of practice size. Medium-sized practices had a larger share of their specimens come from hospital outpatients than did small or large practices (Table 5).

TABLE 5: Average Source of AP Specimens Among Respondents Who Were "Extremely Confident" or "Very Confident" in Their Responses, by Practice Size

	Hospital: Inpatient	Hospital: Outpatient	Nonhospital (eg, outreach; physician office)	Pathology consults (from different institutions)	Other Source	Unsure
All (n=123)	31%	31%	26%	3%	8%	2%
Small (1-9,999 specimens; n=46)	33%	20%	29%	0%	0%	0%
Medium (10,000-24,999 specimens; n=28)	33%	40%	24%	0%	0%	0%
Large/Extra Large (25,000+ specimens; n=43)	34%	27%	27%	1%	0%	0%

* "Other" includes central laboratories, forensic laboratories/medical examiners offices, government or military facilities, physician-office laboratories, blood centers, and certain nonclinical settings.

Totals may not sum to 100% due to rounding.

Sources of Practice Revenues

On average, hospital-based practices—both those in academic and nonacademic settings—received about 70% of their revenues from specimens provided from hospital inpatients and outpatients. By contrast, nearly 60% of revenues for independent laboratories came from outside the hospital setting (Table 6).

TABLE 6: Average Source of Revenue Among Respondents Who Were "Extremely Confident" or "Very Confident" in Their Responses, by Practice Setting

	Hospital: Inpatient	Hospital: Outpatient	Non-hospital (eg, outreach; physician office)	Pathology consults (from different institutions)	Other Source	Unsure
All (n=102)	26%	29%	27%	3%	8%	8%
Academic Hospital/Medical Center (n=20)	35%	34%	17%	4%	1%	10%
Nonacademic Hospital/Medical Center (n=45)	34%	38%	17%	1%	3%	7%
Independent Laboratory (n=22)	9%	15%	58%	5%	8%	4%
Other* (n=15)	13%	15%	18%	<1%	38%	15%

* "Other" includes central laboratories, forensic laboratories/medical examiners offices, government or military facilities, physician-office laboratories, blood centers, and certain non-clinical settings.

Totals may not sum to 100% due to rounding.





Sources of Payments to Pathology Practices

On average, nearly 60% of total practice revenues in 2015 were paid by two sources: commercial health plans (35%) and traditional Medicare (23%). Other major sources of revenues, in decreasing order, included payments from hospitals for services provided, such as Part A services (8%); state Medicaid programs (7%); Medicare Advantage (ie, managed care) plans (5%); and self pay (4%) (Figure 8).

Commercial health plans and traditional Medicare accounted for well over half of payments to practices, regardless of practice setting. Practices based in academic hospitals/ medical centers tended to receive a greater share of income from traditional Medicare than did other settings, while nonacademic hospitals and independent laboratories received a greater share from commercial insurers (Figure 9).

FIGURE 9: Average Source of Revenue in 2015 Among Respondents Who Were Extremely Confident or Very Confident in Their Responses by Setting and Type of Payer (n=101)



"Other" category excluded due to small sample size.

Practice Staffing

On average, responding practices employed an average of 10.2 FTE pathologists. As reported earlier in Figure 2a, about one-half of these practices had five or fewer FTE pathologists, and 27% had 10 or



fewer FTEs. Average practice size varied substantially by practice setting. For practices based in an academic setting, the average practice had 23.6 FTE pathologists. Nonacademic, hospitalbased practices tended to be much smaller, with an average of only 4.8 FTE pathologists per practice, while independent laboratories had an average of 4 FTE pathologists per practice (Figure 10).

* For the purposes of calculating the number of full-time equivalent pathologists, part-time pathologists are counted as 0.4 full-time pathologists.

TABLE 7: Pathologist Assistant (PA) Staffing Expressed as PA per FTE Pathologist, Among Those Practices Employing PAs, by Practice Setting

	SETTING					
	Academic Hospital/ Medical Center	Nonacademic Hospital/ Medical Center	Independent Lab	Other*		
Number of practices with PAs	42	55	11	12		
Average number of PAs per FTE pathologist	0.20	0.33	0.29	0.28		

* "Other" includes central laboratories, forensic laboratories/medical examiners offices, government or military facilities, physician-office laboratories, blood centers, and certain nonclinical settings.

About one-half of the responding practices (n=120) reported having pathologist assistants (PAs) employed in their practice. Most of these practices were hospital-based practices, both academic and nonacademic. On average, practices based in academic hospitals/medical centers that did employ PAs had 0.2 PAs per FTE pathologist, while those in other settings had about 0.3 PAs per FTE pathologist (Table 7).

About one-fifth of the responding practices (n=54) reported having PhD scientists employed in their practice. Most of these practices were hospital-based practices, with the vast majority being based in academic hospitals/medical centers. On average, practices based in academic hospitals/ medical centers that did employ PhD scientists had 0.2 PhD scientists per FTE pathologist, while those in nonacademic hospitals/ medical centers had about 0.3 PhD scientists per FTE pathologist (Table 8).

TABLE 8: PhD Scientist Staffing per FTE Pathologist, Among Those Practices Employing PhD Scientists, by Practice Setting

	SETTING						
	Academic Hospital / Medical Center	Nonacademic Hospital/ Medical Center	Independent Lab	Other*			
Number of practices with PhD Scientists	38	9	4	3			
Average number of PhDs Scientists per FTE pathologist	0.21	0.26	**	**			
FIE pathologist							

* "Other" includes central laboratories, forensic laboratories/medical examiners offices, government or military facilities, physician office laboratories, blood centers, and certain non-clinical settings.

** Not reported due to small sample size.



In addition to regular staff, 25% of pathology practices had pathology residency training programs. Typically, these training programs have at least eight residents, although a small number had fewer. Most of the residency programs had between nine and 20 residents in 2015 (Figure 11).

A total of 45 practices reported that they have trainees in pathology fellowship positions approved by the Accreditation Council for Graduate Medical Education (ACGME), and 27 had trainees in non-ACGME-approved pathology fellowship positions . Eighteen practices had only ACGME-approved pathology fellowship position, and 25 had both ACGME-approved and non-ACGME approved positions. One practice had only a non-ACGME pathology fellowship position (Figure 12).

FIGURE 12: Practices With Trainees in Fellowship Positions (n=211)



¹Many non-ACGME approved pathology fellowship positions may be, effectively, junior faculty at an academic medical center or major hospital.

Pathologist Job Market

Employment Opportunities for Pathologists in 2015

FIGURE 13: Number of Pathologist Positions Practices Sought to Fill in 2015 (n=215)



Over 40% of surveyed practices sought to hire at least one pathologist in 2015. Half of these positions were to fill previously existing positions, and half were to staff a newly created position. More than half of the practices that were hiring in 2015 were seeking to hire more than one pathologist (Figure 13).



Among the 92 practices that hired at least one pathologist in 2015, 41% were in academic hospitals/medical centers, although these practices accounted for only 23% of survey respondents. By contrast, 36% of practices hiring pathologists were in nonacademic hospitals/medical centers, compared to 48% of respondents, and 12% were based in independent laboratories (compared to 15% of respondents). (Figure 14)

FIGURE 14: Settings That Were Seeking to Hire at Least One Pathologist in 2015 (n=92)



* "Other" includes central laboratories, forensic laboratories/ medical examiners offices, government or military facilities, physician office laboratories, blood centers, and certain non-clinical settings.

FIGURE 15: Practices Seeking to Hire at Least One Pathologist, by Size of Practice, 2015 (n=91)



46% of larger practices (those with more than 10 FTE pathologists) indicated that they were seeking to hire at least one pathologist in 2015. But even the smallest practices—those with five or fewer pathologists, which accounted for 52% of surveyed practices—represented 31% of practices seeking to fill positions (Figure 15).

On average, practices that reported they will be hiring in 2015 had 2.3 positions to fill.

Nearly all of the practices that sought to hire pathologists filled either all or some of the open positions (Figure 16). The most frequently cited reasons for not filling positions were an inability to find qualified candidates (13 practices), an inability to meet compensation requests (seven practices), and the applicant's geographic concerns (four practices). (Figure 17)

FIGURE 16: Ability of Pathology Practices to Fill Open Positions, for Pathologists (n=94)



Respondents were asked to identify up to three areas of subspecialty expertise that they were seeking to fill with their open positions. Nearly half of these practices sought pathologists with expertise in general pathology. Other widely sought areas of subspecialty expertise include hematopathology, gastrointestinal

FIGURE 17: Reasons for Not Being Able to Find Qualified Candidates for Open Pathologist Positions (n=26)



pathology, and cytology (nongynecologic). Some areas of subspecialty expertise were primarily sought in academic practice settings (pulmonary pathology, microbiology, next generation sequencing, cytogenetics, fine-needle aspiration performance, and medical renal pathology), while some were predominantly sought by nonacademic practices (dermatopathology, flow cytometry, bone marrow aspiration/biopsy, and autopsy). (Figure 18)

Note: Percentages do not sum to 100% because some respondents provided more than one answer.

Medical renal pathology Fine-needle aspiration (FNA) (performance) Cytogenetics Autopsv Next Generation Sequencing (NGS) Informatics; Pathology and/or Clinical Bone marrow aspiration/biopsy (performance) Other Some widely Flow cytometry Microbiology sought areas of Genitourinary pathology Number of Practices subspecialty Clinical chemistry Forensic pathology expertise for Bone/soft tissue Pulmonary pathology practices included Pediatric/perinatal pathology Neuropathology hematopathology, Cytology, gynecologic (pap smears/liquid based preps) GI pathology, and Gynecologic surgical pathology Transfusion medicine cytology (non-GyN). Breast pathology Molecular pathology Dermatopathology Cytology, non-gynecologic (fluids and FNAs) Gastrointestinal pathology Hematopathology General pathology only 0 10 15 25 40 45 5 20 30 35 Academic Medical Centers Nonacademic Hospitals Independent Labs Other

FIGURE 18: Practices' Top 3 Choices of Subspecialty Expertise for Filling Open Positions, by Practice Setting (n=92)

Future Hiring Plans

About 63% of practices planned to hire at least one pathologist within the next three years, and 25% expected the practice to hire more than one pathologist during that time period. About 27% of practices had no plans to hire pathologists in the next three years, and another 27% were unsure of their future hiring plans (Figure 19).

Some of these new positions were due to expected retirements among current staff. Over 40% of respondents expected at least one retirement in their practice in the next three years (Figure 20). Just over one-third (35%) did not expect any retirements, and 22% were unsure. Retirements were expected among practices of various sizes (Figure 21). FIGURE 19: Number of Pathologists Practices Expect to Hire in Next Three Years (n=224)



FIGURE 20: Number of Pathologists Expecting to Retire Per Practice in Next Three Years (n=220)



FIGURE 21: Percent of Practices Expecting Pathologist Retirements in Next Three Years by Practice Size (n=94)



Business, Regulatory, and Legislative Issues Affecting Pathology Practices

Practices Undergoing Organizational Change

Consistent with other areas of health care, pathology practices were subjected to various organizational changes consistent with an evolving health care financing and delivery system. About 3 in 10 respondents reported that their practice was involved in some kind of organizational change in 2015. The most frequent change was that a hospital served by the practice was involved in a merger or acquisition, an event experienced by 20% of respondents' practices (Figure 22).



FIGURE 22: Organizational/Structural Changes Experienced by Pathology Practices in 2015 (n=208)

Overall, 18 respondents (9% of respondents) reported that their practice merged with another organization or group. Of these 18 practices:

- 10 merged with a hospital or integrated delivery network (ie, a network of facilities and providers that offer a continuum of care to a specific geographic area or market)
- Four merged with a multispecialty group
- Three merged with a pathologist-owned group

Participation in Accountable Care Organizations

About 30% of respondents currently contracted to participate in one or more accountable care organizations (ACO), 4% were negotiating to participate in an ACO, and 6% were exploring the feasibility of forming or joining an ACO. About 40% of respondents' practices did not contract with an ACO, although a large number (27%) of those said they may consider doing so in the future (Figure 23).



FIGURE 23: Participation in Accountable Care Organizations (n=207)

- Currently contract to participate in one or more ACOs
- Actively negotiating to participate in an ACO
- Currently exploring the feasibility of forming/joining an ACO
- Previously participated in an ACO but no longer do
- Do not contract with an ACO but may consider it in the future
- Do not currently contract with an ACO and do not plan to consider it in the future
- Unsure

FIGURE 24: How Pathologists Receive Base Compensation From ACOs (n=61)



Among the respondents whose practices participate in ACOs, the most common method used by the ACO for compensating pathologists was fee-for-service payments at or above rates paid by Medicare or the health plan's standard fee schedule (46%), followed by discounted fee-forservice (21%) and salary (18%).

FIGURE 25: Percentage of Practices Whose Pathologists Receive Financial Incentives or Shared Savings for ACO Participation, Among Those Practices That Participate in At Least One ACO (n=62)

Does your practice (or do pathologists in your practice) receive any financial incentives or shared savings for ACO participation?



Although ACOs are premised on improving quality and reducing costs, and incentivizing participants for their contributions to achieving these goals, relatively few (24% of the 62 respondents to this question) reported that their practice received financial incentives or shared savings for ACO participation.

Issues Facing Practice Leaders

Respondents identified the most important factors that influenced the development of business plans in the medium term (3–5 years). Respondents were asked to rate each item on a five-point scale, with one being "not important" and five being "very important" (Figure 26).

FIGURE 26: Most Important Factors for Developing Business Plans in the next 3-5 years



Surveyed practices were asked about the likelihood that their practice was to experience significant market impacts within the next three to five years. Over 60% of practices reported that increased roles in molecular pathology were very or somewhat likely. Practices also reported that the following events were very likely to occur in the future:

- Join an ACO or other alternative payment model (20%)
- Add hospital contract (19%)
- Add commercial health plan/insurance contract(s) (18%)
- Participate in joint venture/joining an alliance (15%)

Few respondents felt their practice was going to experience a change from employed to independent contractor (10%) or they were going to sell their practice (5%).

Nearly 50% expected to add commercial health plans/insurance contracts, and 35%–40% thought it somewhat or very likely that their practice would add hospital contracts, participate in an ACO or other alternative payment model, or participate in a joint venture or alliance (Figure 27).



FIGURE 27: Likelihood of the Practice Experiencing the Following Changes in the Next 3–5 Years

Respondents also identified up to five advocacy issues that were most important to their practice, ranking those from one to five, with one being the most important issue, two being the second most important issue, etc. Figure 28 shows the mean values for each issue. The lower the number, the greater the importance of the issue to practices. The most important issues identified were concerns about Medicare payment cuts, self-referral of anatomic pathology specimens, and direct billing for pathology services.

FIGURE 28: Ranking of Most Important Advocacy Issues to Pathology Practices



Medicare payment cuts ranked most important advocacy issue facing pathology practices.

Closing Comments

The CAP Practice Leader Survey was designed to provide a primary source of socioeconomic data on pathology practices operating in the United States. This report is provided for information purposes only. It is not a complete analysis of all pathologist groups in practice. All opinions expressed are subject to change without notice and information is based on self-reporting from a limited number of practices. Data are considered reliable but no representation is made by the CAP as to their completeness or accuracy.

The need for timely information on pathology practices is essential as the health care system continues to adjust to the demand for measurable quality and more cost-effective care. The CAP hopes that the data from this survey will provide valuable insights about the current state of pathology practice. Please provide your thoughts about this survey, including areas and questions for further research and analysis, to PracticeSurvey@cap.org.