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Medical Devices Hit the Radar Screen

If buyers and sellers don't check the rising cost of implantable medical devices, the government just might do it for them.

By Bill McIlhargey and John Murray

(In the Winter issue of The Journal of Healthcare Contracting, national accounts veteran Bill McIlhargey pointed out the need for buyers and sellers to get to "yes" when contracting for physician-preference items. In this article, McIlhargey and John Murray of Premier point out the consequences of the industry's failure to do so.)

When it comes to healthcare products, physician-preference items capture more than their fair share of attention, either because of the excitement of breakthrough technology or the less exciting business aspects of buying and selling.

Implantable medical devices are a \$14.6 billion industry, representing such products as pacemakers, heart valves, stents, hip and knee replacements, defibrillators (ICDs) and a host of other technical marvels. They are projected to command an 11 percent average annual increase in U.S. demand through 2007, according to the Freedonia Group ("Implantable Medical Devices to 2007," October 2003). Despite the hype surrounding these products, however, more and more attention is now shifting to the business practices surrounding them, particularly their contribution to the high cost of healthcare.

Central to the discussion is the high SKU price of implantable medical devices (keeping in mind that medical devices cannot be benchmarked against traditional commodity products). To visualize the impact of these devices, think of technology employed under the following two platforms, both of which influence the business dynamics underpinning manufacturers' go-to-market strategies:

Pure play. Products dubbed as "disruptive technology" bring a revolutionary contribution to the next level of

care. Drug-eluting stents would be an example. Driven by innovation at its best, these products tend to have short life cycles, with new technology and products always one step behind. Obviously, such products live and die on the speed of getting to market.

Skill-based. These products are much more evolutionary and deal with incremental changes. They are more technique-oriented, like orthopaedic reconstructive joints, and rely on one-to-one training and support, which spawn the supplier/surgeon relations that become a basis for product dependence.

In the aggregate, the products resulting from both technologies are highly physician preference. Because of regulations, such products demand that suppliers bear the responsibility for costly educational support to the clinical community.

Why the Attention?

Implantable medical devices improve the quality of life. Procedures involving vascular stents, reconstructive joints, cardio defibrillators and spinal instrumentation have captured the imagination of every physician eager to become the regional expert for their delivery. With favorable reimbursement policies, hospitals, surgery centers and now specialty hospitals are clamoring to be the facility of choice in their area. (*The New York Times*, "Barred as Rivals, Doctors See Some Hospitals in Court," April 2004). However, consistent economic pressure is catching up to these "pearls of profit." Consider:

According to IMS data (IMS Hospital Supply Index, Plymouth Meeting, Pa.), there is a 10.7 percent compound annual growth rate on pricing for medical-surgical products since 2001. Of these products, implantable

medical devices represents 89 percent of the dollar spend and 11.8 percent of the average growth rate, while the remaining products show a 2.6 percent rate. Most notable are: grafts and fabrics (23.8 percent), orthopedics (17.5 percent), pacemakers (12.9 percent) and diagnostic and therapeutic (11.2 percent), although the last includes dramatic price erosion of bare metal stents, offset by higher priced drug eluting stents.

The issue for providers is not the increased price of these devices, but rather, providers' inability to quantify their impact on the level of care. As system insiders will agree, a primary concern and challenge is measuring the quality of care, and then balancing that against the perception of the consuming public. This may encourage movement beyond the current model, which separates fiscal and clinical decision-making, to one that aligns the two. Unfortunately, we fear this alignment will require a dramatic increase in financial responsibility for the consumer.

Why Is This Difficult?

Why is it so difficult to obtain an economic solution for products that clearly contribute so much to the healthcare system? One reason is the traditional application of buying and selling practices. The more widgets you buy, the greater the buyer's expectation for a lower price. This is true, of course, only if supply chain dynamics are determined and controlled by the purchaser.

But in the case of implantable medical devices, the dominating influence and resulting control resides with the physician, partly because it is he or she who bears the liability for the surgical procedures in which these devices are used. Because of this, the purchaser plays the role of facilitator—an uncomfortable role at best,



Bill McIlhargey

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if that person is charged with reducing overall supply costs.

However, it should be noted that as providers continue to struggle with the economic pressures of reimbursement, they are recognizing that supply chain executives must bridge clinical attitudes with economic realities. In fact, several hospitals have initiated successful service line teams, comprised of surgeons, nurses, supply chain and hospital executives, which focus on process and utilization of good comparative information for decision making.

Problematic Issues

Before declaring that the healthcare system is moving toward a solution to the business challenges surrounding implantable med-

ical devices, we need to have a well-grounded understanding of the underlying problems.

First and foremost is the issue of liability, which is the responsibility of the physician, and which is dependent on the skill they employ during procedures.

Second is the dilemma surrounding "best practice," clouded by the very nature of physician preference as well as supplier marketing. Equally concerning is the lack of benchmarks for revolutionary vs. incremental advances, particularly in technologies such as biologics.

Third are the supply chain implications of implantable medical devices, which are not only unrecognized, but also undervalued by the purchasing community. Unlike other products, suppliers have been required to control the inventory and instrumentation used during delivery. Providers have grown accustomed to this service, and in some cases have abdicated nursing support for this activity.

Fourth, the various components in the healthcare system lack alignment in financial incentives. The payment process has divided the providers of care (hospi-

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tals) from those who deliver care (physicians), leading to a struggle for resources and paving the way for specialty hospitals and ambulatory surgery centers to capture the more lucrative procedures.

Fifth, economic buyers are concerned about the acquisition and consolidation of start-up medical device companies, providing a never-ending supply of new products from fewer companies, i.e. those with deep pockets and finely tuned distribution channels.

Sixth, the frustration levels of the buyer and seller have polarized the two. Buyers' lack of familiarity with, and training on implantable medical devices make them ill equipped to balance their administration's cost concerns with the clinical needs of the staff. At the same time, supplier's ability to align with surgeons and win continual price concessions has shielded many of them from the ever-deepening financial plight of the healthcare industry. Meanwhile, consumed by the demands of their investors, suppliers face mounting pressures to grow margins.

These issues pose formidable barriers between buyers and sellers, with dangerous implications.

Where Will this Lead?

What will happen if buyers and sellers fail to build a business model for implantable medical devices, which allows both of them to meet their objectives? At some point, an outside influence with a financial interest will step in.

The government would seem to be the likely candidate, considering that it contributes more than 50 cents of every dollar spent on healthcare. Given the precariousness of the Medicare Trust Fund, it is clear that CMS – the agency that administers Medicare – has the ability and the motivation to “reset” the process, perhaps interjecting a bureaucratic methodology that could seriously jeopardize the productivity needed in a competitive system. Dramatic costs increases during the past couple of years have made healthcare costs a prime target in the 2004/2005

political process.

Looking further, one can see that years of negotiating with managed care companies have left hospitals with little in the way of margins. In fact, it is our belief that threats from hospitals to walk away from the negotiating table have led insurers to grant yearly cost increases to hospitals, effectively making the insurers dependent on the business prowess of the hospitals. This would be a major contributor to the double-digit rate increases for health insurance experienced in the past several years by corporations and consumers.

Would it then be far fetched for this industry, given its regional strengths, to pursue direct supplier contracting with manufacturers of implantable medical devices? What's more, why wouldn't large corporations want to do the same thing? Consider the \$5.1 billion cost projected for this year's healthcare claims of General Motors,

the largest private provider of healthcare benefits in the United States.

For our healthcare system to venture down this path could be much more painful than the dilemma in

which we currently find ourselves. Supplier margins would probably be the early victim, although it is conceivable that suppliers could gain early efficiencies by partnering more closely with consumers. However, in the long run, we believe the market would eventually revert to an all-play, all-vendor situation, which would then demand higher SG&A expenditures from the suppliers. Mean while, buyers will have abdicated profitable margins on lucrative procedures, while further distancing themselves from their physician staffs.

The final stage of this economic cascade could come in the form of “passed down co-payments” to the consumer – you and me. And does this not eventually lead to tiered care, which is delivered based on the individual's ability to pay?

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Solutions

We believe that solutions do exist that salvage existing parameters, and that a buyer/ seller model can be created to embrace the multiple influences that one finds with implantable medical devices.

The first is the development of benchmarks. Evaluating the cost of quality has been a moving target that avoids our best efforts. Yet devising measurable quality standards is doable – not across medical conditions, but rather by specific clinical treatments. For example, the Hospital Quality Incentive Demonstration Project launched by CMS and Premier has identified five conditions, four of which involve implantable medical devices. This effort rates hospitals by individual performance and then financially motivates them to a higher performance. This is a positive step toward aligning incentives, albeit between only two components.

The second solution is subsidizing medical malpractice insurance. Physicians continue to be financially challenged by ever increasing premiums, and are looking for relief. This is a clear opportunity for partnering. Provider organizations such as HCA, along with individual facilities like Grand View Hospital in Sellersville, Pa., and Akron General in Akron, Ohio, are developing and/or offering liability coverage through risk retention groups and captive-insurance companies. Such an approach can help motivate physicians to participate in comprehensive risk-management and quality improvement programs. Furthermore, make no mistake about it: This has the far reaching potential of rebuilding surgeon relations, long at issue in building collaboration with administration.

A third solution involves intensifying collaboration between the hospital and its physicians. Of benefit to the physician is better patient outcomes/satisfaction, more efficiency for his or her practice and, of course, greater income. Benefits to the hospital include increased market share, reduced procedure

costs and good physician relations.

Finally, all employers should “set the stage” for responsible decision making by their health consuming workers. Amending the Internal Revenue Code (Medicare Prescription Drug and Modernization Act – December 2003) provides consumer tax advantages to save for individual care needs. The creation of Health Savings Accounts (HSAs) is a direction toward consumer financial responsibility. For effective implementation, it is imperative for employers to not just communicate available options, but also educate consumers on the impact of their decisions.

Readers are free to agree or disagree with our observations. However, realizing that we must sustain the enormous contributions that implantable medical devices have made to improved health, let us at least agree that our healthcare system requires more attention and involvement from all its constituents. **JHC**

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