

*The Journal of*

# HEALTHCARE CONTRACTING

*Providing Insight, Understanding and Community*



## How One GPO Is Helping IDNs Enhance Revenue

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# Contracting for Physician-Preference Items

**Aligned objectives are a must on the part of all stakeholders.**

By Bill McIlhargey

**The term “physician-preferred products” is as broad** as the number of physicians in this country. For our purposes, they are products that physicians believe will ultimately produce a higher quality of life for their patients. They typically call for specialized training on the part of the surgeon, and frequently represent some kind of liability risk associated with their use and expected outcomes. (Because my background is in orthopedic medical devices, I will focus on them.)

I would be remiss if I didn't draw a distinction between products that represent true technological breakthroughs and those that provide only incremental advantages. This is a contentious issue with those who keep their eye on cost/outcome ratios, and one that won't be resolved in this article. However, I recognize the similarities of both products and their need for a platform of high-profile surgeons to expound upon their virtues.

How can physician-preference products be purchased by hospitals in a manner that accommodates clinical *and* financial influences, yet still satisfies responsible supply-side economics? Contracting plays a key role. But here's the rub:

If there's one thing we've learned in 25 years of national contracting, it's that healthcare is, indeed, a local business. It is influenced by unique processes and relationships, which, in turn, reflect local differences in infrastructures, business strategies and utilization patterns. For buyers and sellers, these differences provide opportunities and frustrations. Nowhere is this truer than in the area of orthopedic implants.

## Who's on First?

To understand the buying and selling of orthopedic

implants, let's first agree on (or at least acknowledge) the fragmentation of buying influences in the typical acute-care hospital. Clearly, the traditional and still dominant player is the orthopedic surgeon (who, as mentioned before, also shoulders the liability associated with the product). However, a host of additional influences have arisen during the past decade, including hospital purchasing departments, regional offices (including everything from

IDN administration to proprietary corporate offices and/or state or regional affiliations for community centers) and, of course, national group purchasing organizations.

With the advent of prospective payment in the 1980s, hospitals turned their attention to reimbursement in the form of diagnosis-related groups, or DRGs. An early profit winner for hospitals was DRG 209 – Major Joint and Limb Reconstruction. This was true despite this DRG's complexity in terms of

instrumentation, surgeon training, product materials and, of course, supplier loyalties. Charged with managing supplies, hospital purchasing departments initially seemed satisfied securing from their vendors the *gratis* use of implant

instruments (which typically cost between \$20,000 and \$50,000).

Later, emboldened by their success in lowering their costs for medical commodities, purchasers gave renewed attention to orthopedic implants, whose price increases exceeded yearly inflationary standards. However, now these economic buyers were more imaginative in their efforts to curtail costs associated with DRG 209. Partnering with hospital staff, they developed protocol



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# Physician-Preference Contracting

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standards, capped procedural payments, elaborate demand utilization schedules and volume-related price matrices.

For the most part, these efforts fell short of their intended purpose. In fact, they merely inflamed the natural rift between administrative and clinical factions. On the one hand, hospitals tried to limit the surgeon's product choice in order to attract competitive bids. At the same time, surgeons quickly tired of economic credentialing and getting questioned about their relations with vendors. So they searched for options they felt would give them more control over the delivery of care, including aligning themselves with nearby hospitals viewed as more friendly to their practices, or moving their practices to emerging specialty hospitals in which they might have financial involvement.

## Pricing Inconsistencies

Despite the fact that orthopedic devices (as well as cardiology and spinal devices) might be considered the last bastions of clinically controlled supplies in the hospital, one should not construe that clinicians are oblivious to the cost of the goods they use. In fact, those hospitals with a focus on DRG 209 do, indeed, receive discounts. The problem is, these discounts are inconsistently applied, controlled in large part by local sales managers operating under the premise of "what the market will bear."

Local discounts routinely reflect the vendor's local market share, the depth of the vendor's exposure within the facility, the vendor's relationships with clinicians and the facility's commitment to national or regional contracts. The inconsistency of these discounts has frustrated purchasing professionals and broadened the gulf between them and the vendors.

Consider the purchasing process from the perspective of the *economic buyer*:

- Held accountable by administration for supply costs, the materials manager is put in the uncomfortable role of merely facilitating the payment for products chosen by the surgeons.
- Tight surgeon/supplier relationships undermine the ability of the materials manager to obtain discounts based on volume. In fact, there's little correlation

between the cost and volume of physician-preference items, particularly, orthopedic implants.

- Because materials managers fail to understand the value that suppliers can provide to clinicians, they resist suppliers being present during (orthopedic) procedures.
- Purchasing professionals are frustrated with the complexity of national GPO agreements and the inability of GPOs to effectively implement standard pricing. What's more, they know that GPOs have devoted minimal resources to support the roll out of national agreements for these difficult agreements.

Now consider the purchasing process from the perspective of the *supplier*:

- Distribution channels have always been geared to supporting procedural delivery and surgeon training. Suppliers view attention to purchasing and economic value as a non-productive, inefficient use of their sales forces.
- For the most part, suppliers believe that hospitals frequently misstate their financial position vis-à-vis DRG 209 and that, in fact, they make money on the procedure. They believe that inefficient cost accounting clouds the issue. The bottom line is that suppliers feel unjustly targeted for their hospital customers' unprofitable procedures. Of course, their sales reps share that mistrust with the surgeons, further strengthening the surgeon/supplier relationship.
- Suppliers feel that economic buyers refuse to recognize the financial contributions that suppliers make to hospitals, including providing instrumentation free of charge, providing products on consignment, and so on. Suppliers believe hospitals have little interest in trying to understand the suppliers' costs associated with supporting clinical procedures.
- Suppliers are disappointed with national GPOs' efforts to contract for physician-preference items, believing that national contracts provide neither sales efficiencies nor incremental volume. In many suppliers' minds, national contracts have done only one thing – establish a new (lower) pricing framework from which local hospitals can benchmark their efforts.

It's not surprising that the natural buyer/seller tension has grown over the years, driving sellers to

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intensify their relationships with clinicians. Nor is it surprising, as noted before, that the rift between the clinical and administrative functions within the hospital has only grown wider.

So what's the bottom line regarding pricing inconsistencies?

- Minimal impact on the cost of orthopedic implants.
- Increased frustration on the part of clinicians and administrators.
- Closer supplier/surgeon relationships.
- An increased credibility gap between buyers and sellers.
- Polarization of each party's position, with little movement by sellers, surgeons or economic buyers.

## What's To Be Done?

Is this the status quo? Can suppliers of orthopedic devices continue to operate their businesses based on demographics and expanding relationships with surgeons? Can economic buyers continue to ignore the impact that suppliers of physician-preference items can have on the quality of care? Can surgeons continue to move their practices in order to get the products they want?

Improvement in the way physician-preference products are bought and sold can only come about when all parties understand the needs and value of the others.

Yes, it's conceivable that buyers and sellers could shrug off their distrust of each other. But it's highly unlikely they will do so without outside help. The key is to establish a collaborative platform between them. This can only be done by taking the time to identify the underlying values and barriers residing on all sides.

The following tips are offered to help coach the process and generate momentum for its acceptance:

- **Start where the action is.** This doesn't mean that arm's-length influences could not be part of the solution, but rather, that values, opportunities and perceptions reside locally and need to be resolved there.
- **Throw away standard buying/selling models.** Line item benchmarking, cross-reference evaluations and SKU pricing are not the tools we're looking for here. Realize that understanding and innovation are the keys to success, and that they can only exist after both sides strip away their egos and place their strengths and weaknesses on the table for collaborative leverage.

- **Establish a reciprocal platform with the benefit of knowledgeable, third party insight,** whether from affiliated GPOs, supplier/buyer corporate offices or outside consultants. It's important that this third party is credible and that it possesses a full understanding of industry frustrations.
- **Develop a *quid pro quo* early in the process.** Enough of holding the cards close to the vest. Buyers and sellers know what has failed to work in the past, so stop wasting time building higher barriers. Instead, put the cards on the table early. Doing so almost certainly requires assistance from an outside source.
- **Pursue extended opportunities.** Given that price-for-volume has failed to work in this arena, attention should be paid to the underlying values, strengths and weaknesses of all parties to determine what drivers are required to satisfy these values.
- **Create a simplified agreement.** Restrict your contract language to intent and measurable performance. Don't get bogged down in clauses that limit the intent of your agreement, but do include milestones that can be evaluated regularly.
- **Establish performance evaluations.** Agree to review your milestones and regularly evaluate performance.
- **Don't lose sight of the clinical interest.** Although we've focused on the business process, there's little to sustain without addressing the result of this collaboration. Performance outcomes, knowledge transfer and physician supply chain frustrations are all plausible areas to develop, and will perform an ongoing service to both hospital and surgeon.

Those of us in the contracting arena have an opportunity with physician-preference products. As students of the contracting process, we should recognize when and where we need to "adjust our sights" and dismantle the cloak of distrust.

Our job is to find a way to say "yes" and not encourage the barriers of "no." **JHC**

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