

# Aligning Financial Incentives: Future State

*Pursuit of Value for Medical Devices:  
Strategies for Collaboration  
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# Objectives

- Review the current trends in spine/orthopedic alignment among providers, physicians, and vendors
- Dispel the myths about the real drivers of value (savings)
- Discuss potential, alternate strategies for alignment – the Future State

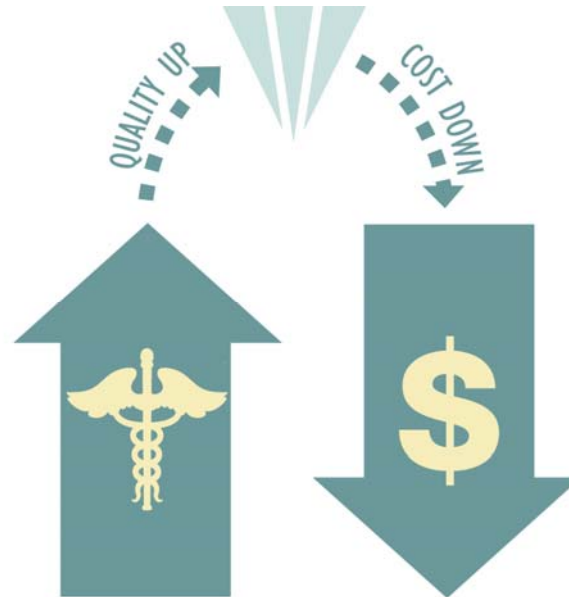


# Premier, Inc. – A Primer

- Four major divisions
  1. The Group Purchasing Organization – aka, “Purchasing Partners”
    1. The most visible and known area of Premier
    2. Negotiation of all contracts for medical supplies, equipment, etc.
    3. Relationships with all contracted suppliers maintained here
  2. Data/Information services, databases, etc. – aka, “Informatics”
  3. Premier Insurance Management Services (PIMS)
  4. Premier Consulting Solutions (PCS)
    1. A consulting division of Premier that competes with other large, national consulting firms; has arms-length relationship with the GPO
    2. No requirement for Premier hospitals to utilize consulting services
    3. Customer base varies from year to year; goal is to support the requested needs of hospitals in a variety of areas

# Premier's Strategic Objective

***“Our hospitals will operate at the **lowest cost levels** and the **highest quality levels** in their respective markets.”***



**Improved Patient Outcomes**

# High Quality Care at Low Cost is Possible

***We are partners with you over the long term.  
Our success depends on your success.***



## **Our Core Purpose:**

*To improve the health  
of communities.*

## **Our Envisioned Future:**

*Premier hospitals and health  
systems will operate at costs  
in the lowest quartile among all  
similar organizations and at quality  
levels in the highest quartile.*

# Common Messages That We Hear in PCS

Hospital Leaders: We need to remove \$\_\_M by DATE.

Hospital Leaders: We don't know if our \_\_\_ service line is profitable.

Physicians: Don't put me in the middle of negotiation with suppliers.

Physicians: I'll support a process for fair pricing if I can maintain choice.

Vendors: What is my motivation to lower unit price without a growth commitment?

Vendors: I'm open to a real partnership that is mutually beneficial.

# PCS' Implant Management Approach

- Physician engagement in implant expense management is essential *before* interaction with vendors
  - Surgeons must understand the financial climate
  - Setting defined implant selection criteria based on clinical criteria enables physicians and hospitals to optimize performance
- Securing fair and reasonable implant pricing across all vendors and product types enables your health system to optimize patient outcomes and manage limited resources
- Implant costs remain a vital driver of service line profitability, though not the only driver
  - Pricing and utilization should be managed to a defined percent of hospital payment

# Implant Expense Versus Reimbursement

- Following is real data from a blinded Premier member
- Actual implant expense consumes a high percentage of the average reimbursement
  - Do you know your system's ratio of implant expense to reimbursement?

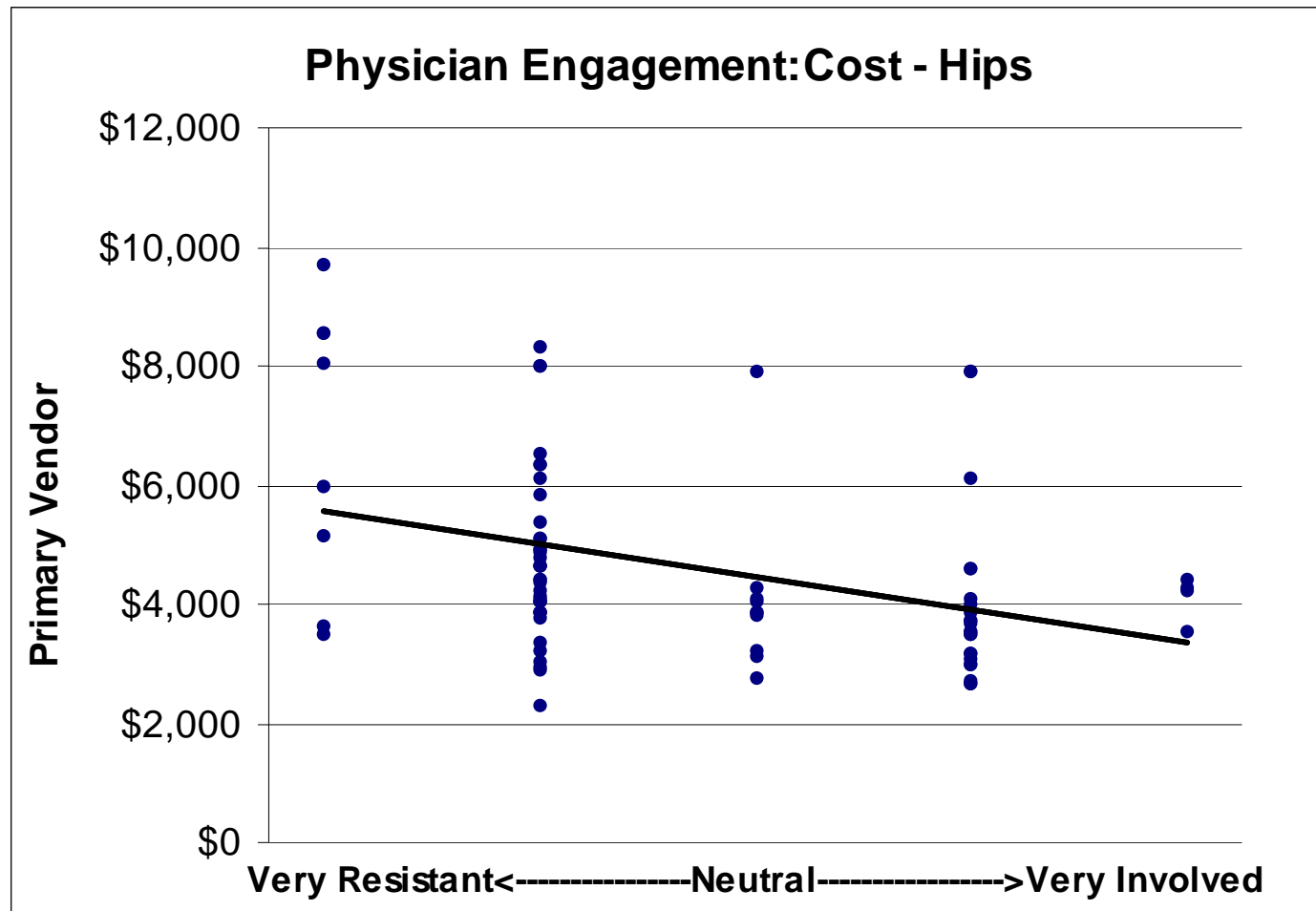
Hospital	% Medicare Cases	Medicare 2007 Reimb	Avg Hip Implant Cost	Hip Volume	Hip Cost % of Reimb	Avg Knee Implant Cost	Knee Volume	Knee Cost % of Reimb	
A	62%	\$10,287	\$7,312	200	71%	\$5,142	500	50%	
B	63%	\$11,763	\$6,824	150	58%	\$5,935	350	50%	
C	56%	\$12,038	\$7,211	40	60%	\$6,086	160	51%	
D	36%	\$11,369	\$6,748	30	59%	\$7,095	40	62%	
E	39%	\$9,905	\$8,202	10	83%	\$8,384	30	85%	
<i>Average</i>	<i>51%</i>	<i>\$11,031</i>	<i>\$7,114</i>	<i>86</i>	<i>64%</i>	<i>\$5,701</i>	<i>216</i>	<i>52%</i>	<b>TOTAL</b>
Savings at Reimbursement Target 1 - 45%			\$924,330			\$796,083			\$1,720,413
Savings at Reimbursement Target 2 - 40%			\$1,161,504			\$1,391,777			\$2,553,281
Savings at Reimbursement Target 3 - 35%			\$1,398,679			\$1,987,471			\$3,386,150

# OrthopedicFocus<sup>SM</sup> Observations

- There IS NOT a statistically significant correlation between the volume\* of implants and unit price
  - R and R-squared values do not represent a “strong” correlation
    - Hips:  $R = -.03$
    - Knees:  $R = -.05$
- There IS a correlation between unit price and the level of physician engagement (i.e., the “credible threat of movement”)
  - R value is stronger and has an inverse relationship to unit price
    - Hips:  $R = -.37$
    - Knees:  $R = -.44$
- *Vendors will, however, provide lower pricing in exchange for incremental volume/market share in the same organization*

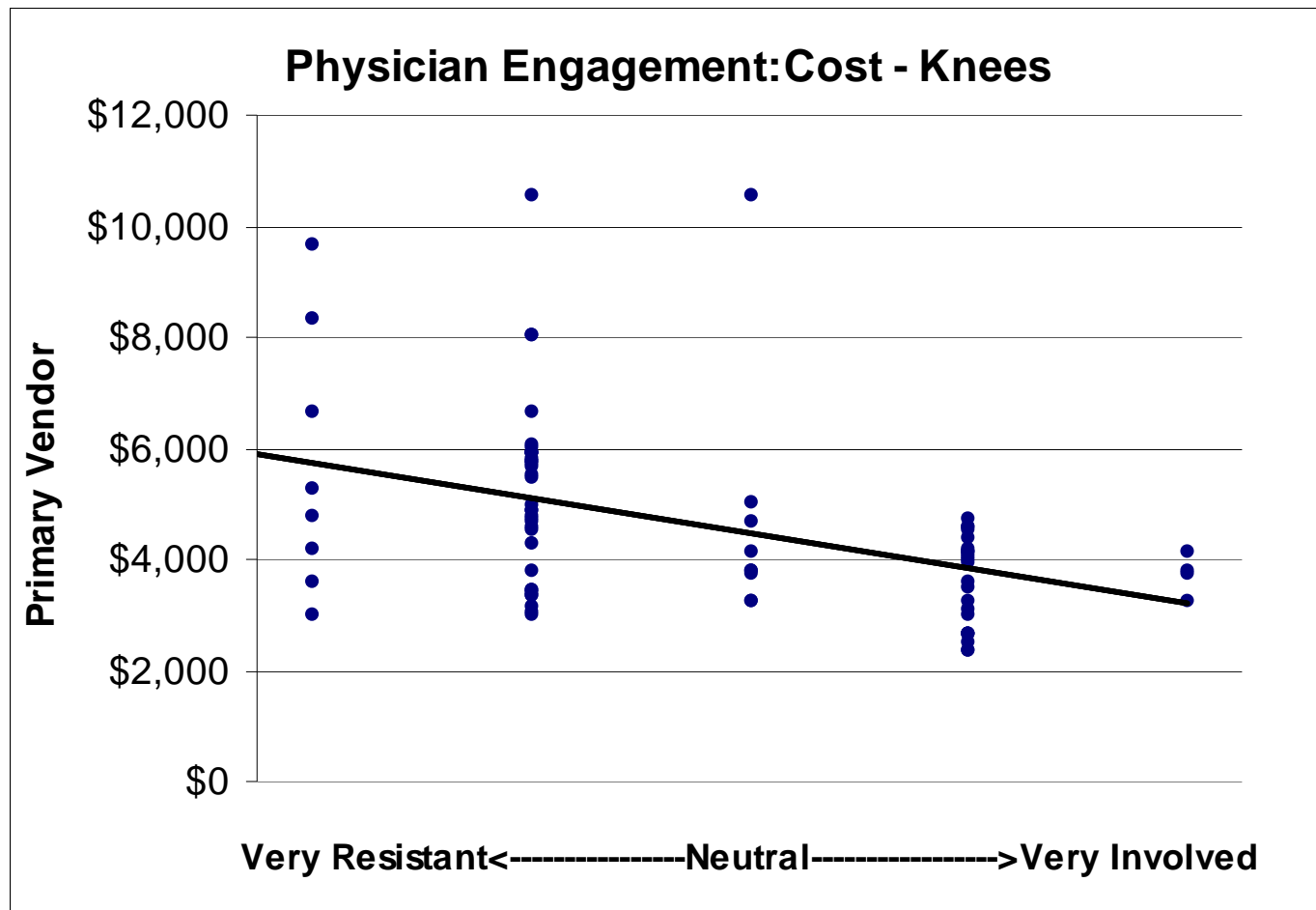
# OrthopedicFocus<sup>SM</sup> - Construct Price vs Physician Engagement (Hips)

- Hips



# OrthopedicFocus<sup>SM</sup> - Construct Price vs Physician Engagement (Knees)

- Knees



# OrthopedicFocus<sup>SM</sup> Observations

- The average number of unique implant suppliers (per hospital) in the OrthopedicFocus<sup>SM</sup> database:
  - Hips – 3.1
  - Knees – 2.9
- Among the best quartile of hospitals (lowest cost/case) in the OrthopedicFocus<sup>SM</sup> database, almost no hospitals were standardized to one supplier
  - Hips – None (0) of the lowest 22 hospitals (in cost/case) were standardized to one supplier
  - Knees – Two (2) of the lowest 22 hospitals (in cost/case) were standardized to one supplier

# Current Market Dynamics – A Conundrum

- Early 1990's – early 2000's
  - Many hospitals standardized from 7+ vendors to 2-3
    - Vendors exchanged lower unit price for the prospect (or reality) of incremental market share (revenue)
- Today
  - Many leaders have fatigue in hospital-physician relations
    - Increased pressure on revenue enhancement and market share growth (hospital-wide) creating more pressure on hospitals to cater to surgeon's product preferences
    - Thus, more and more hospitals likely to tell surgeons, “you can maintain your vendors....we just want a lower price...etc.”
    - *Result:* Vendors being asked/told to lower unit price without necessarily seeing a potential increase in their market share
      - Summary: it can be done, but likely a more protracted, arduous process

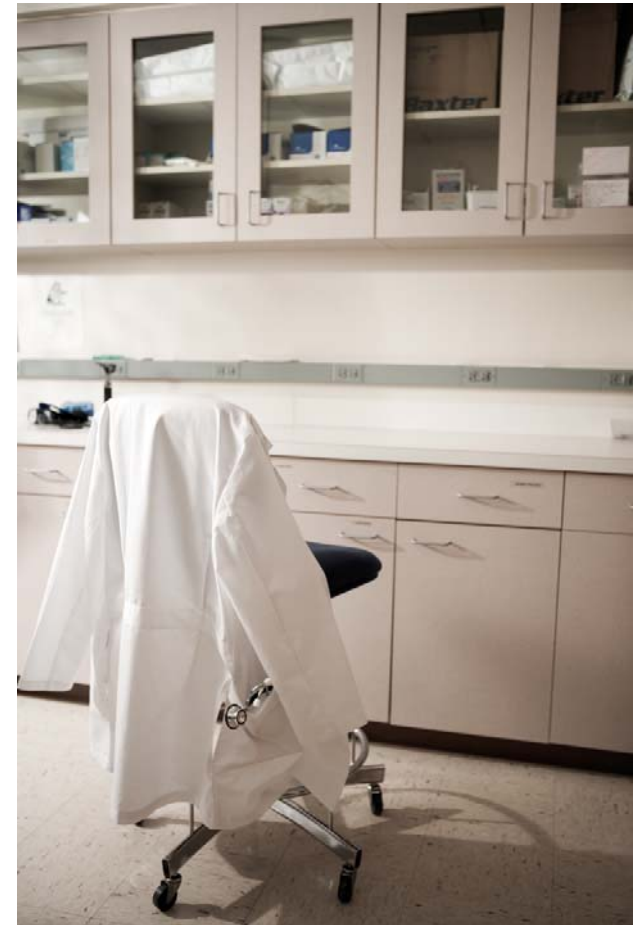
# Is It Really, “Win-Win”?

## Early 1990’s – Today

- Typically, some constituency always “loses”
- Losing/winning commonly defined on the basis of \$ only, typically on the implant \$
  - Hospitals spend less on implants
  - Vendors grow their implant revenue (commissions)
- Both constituencies typically see their benefit erode at some point in the contract term; though, the hospital is more likely than the vendor to see their benefit erode
- *Poker analogy – if you don’t know who the sucker is, then it’s probably you*

# What About the Surgeons?

- Surgeons win via:
  - Maintaining product/vendor selection
  - Reducing hassle factors (e.g., improving availability of block scheduling)
  - Improving the quality of care for their patients (e.g., development of a “Joint Camp” or “Center of Excellence”)
  - Improving capital/technology
    - Hospitals agree to share ~20% of implant savings in the form of capital/technology
      - Navigation equipment
      - Rooms
      - Tools/accessories
  - Improving financial position, as legally permitted



# A New Win-Win-Win Model?

- Since 2006, commercial payers are systematically reducing historical implant mark-ups, impacting surgery margins
- Hospitals are paying 25% higher implant prices because of supply chain inefficiencies
- Other high-tech industries (internet equipment, semiconductors) generate 50% higher returns on invested capital on 25% lower gross margins due to their efficiencies
- Hospitals can achieve similar price reductions by driving Surgical supply chain inefficiencies and implementing a pay for performance program with implant companies

Source: *viaMD, Inc., [www.viamd.com](http://www.viamd.com)*

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# A New Win-Win-Win Model?

- Hospitals and vendors looking for common areas to improve and realize value
  - Example: both hospitals and vendors have sub-optimized expenses via the mis-management (inefficiency) of consigned inventory
    - There is a cost to vendors to carry extra inventory (overhead)
    - This cost is often eventually funded, at least in part, by hospitals
  - Causes (partial) of excess inventory
    - Lack of advanced case notification/scheduling (materials flow)
    - Lack of real-time connectivity among the physician's office, Surgery scheduling, Materials Management, and vendors

# A New Win-Win-Win Model?

- Important considerations
  - Most high-dollar implant cases are elective
  - The physician/patient are the first to know what will be implanted
    - What is the average lead time before the procedure date?
- Potential approach
  - Electronic module (technology) that integrates admitting order, surgery, and materials workflow
    - Preference card automation and pick-list creation
    - Usage capture through bar-code scanning of implants (including vendor trunk stock)
    - Just-in-time inventory and order management
- Potential value
  - Up to 15% of current/invoice cost (price)



# Breaking Old Paradigms

- Both hospitals and vendors must be willing to try a *new approach*
  - Old “contracting” approach will result in the same, often painful, result
  - New approach not designed to replace conventional contract negotiation, but rather to be an augment
- New mindset: process improvement will create operational efficiencies (and resulting savings) *versus* “it all starts with the contract”
- Surgery must be viewed as an integral part of the solution

# Why the Timing is Good Now

1. Competing demands for time (projects) and more limited resources
  - Negates ability to utilize old negotiation tactics
2. Traditional negotiation has trimmed formerly large implant margins of vendors to more discrete levels
  - Large, incremental gain will need to come from a new source
3. Prevalence of more sophisticated data/information systems allows for real-time tracking of results
4. Increased scrutiny of vendor-surgeon relationships may increase the attractiveness of other, optional approaches for some organizations