Implant-oriented GPO pinpoints doctors orders

Up Close with John McGuire

by Rick Dana Barlow

Surgeons routinely don't have enough sizes of them or the right brands. Materials managers grapple with their costs and usage, frequently butting heads with the surgeons who want them. Historically, group purchasing organizations haven't been able to crack their contract code. Now vendors are attempting to prevent hospitals from revealing and sharing pricing information about them, which those vendors classify as confidential.

Whether they involve cardiology or orthopedics, high-priced surgical implants represent one of the few product lines that just about gives everybody a fiscal headache.

John McGuire

That's why *Healthcare Purchasing News* Senior Editor Rick Dana Barlow tapped John McGuire, M.A., CPA, president and CEO, Surgical Implant Services LLC (Jacksonville, FL), to shed some light on this harried specialty area. Surgical Implant Services is a GPO that establishes locally owned physician companies willing to pool their purchasing power by standardizing on implant usage to reduce costs and improve clinical outcomes. McGuire shared his insights on how hospitals and surgeons should work together to manage implant products more effectively.

HPN: The national GPOs have been ill-equipped and largely ineffective in negotiating contracted discounts for such physician-preference products as implants, opening the door for companies like yours. What do those GPOs lack that companies like Surgical Implant Services have? Do you anticipate the national GPOs being able to catch up through customized programs or some other mechanism? Why?

McGUIRE: National GPOs have lacked involvement of the physicians in attempts to standardize product selection and aggregate markets. The selection of high-cost implantable devices has been and should remain the purview of physician specialists who are uniquely qualified to evaluate these products and match the best devices to specific patients. Attempts to standardize this process must align the incentives of the doctors with those of the purchasers, while preserving physician access to the entire marketplace of products.

The SIS model ensures physician choice while allocating a portion of the financial impact of those decisions to the implanting physician. This model is the only one we are aware of that accomplishes this critical goal in a legal, sustainable way that provide doctors with an ancillary revenue stream based on consistent product selection that achieves physician driven product standardization and provides purchasers with substantial discounts on these items without any deviation from operation, start up costs or fees. This concept of supporting physician control of the selection process is inconsistent with the standard approach of most national GPOs and that inflexibility will impair their ability to catch up. Customized programs thus far have relied on data alone, often combined with an imposed restriction of choice that most physicians resist or resent. It's possible that these GPOs could develop programs that meet the needs of physicians, but thus far their approach has primarily focused on external controls and this method is unlikely to advance the objective in a sustainable fashion.

What's the biggest misunderstanding and toughest challenge materials managers have about managing physician preference and how do you recommend they handle them?

Probably the biggest misunderstanding about physician preference is to approach this area with a similar strategy used for non-preference items. Because of technical issues, familiarity, clinical experience, relationships and confidence in vendors, etc., materials managers will have difficulty altering physician preference behavior using coercion or by restricting choice in the interest of standardization. Involving the physicians more fully in the process and designing programs to align their incentives with those of the hospital will be more successful and more sustainable.

The toughest challenge is probably to get physicians interested in what they see as the hospital's problem. As I said, product costs are simply not a big concern for many doctors. The solution is to heighten awareness, learn what issues would motivate the doctors to take a bigger role in cost reduction, and design or adopt programs that provide them with incentives for their efforts and cooperation.

Where's the hospital CEO in this process? And what if he/she sides with the 'revenue-generating' surgeons, as opposed to the 'cost-cutting' supply chain managers?

The CEO should recognize the surgeons as an important customer of the hospital and critical to generating patient referrals and revenue. If a materials manager is looking for him to pick sides in a battle, the war is already lost. There are always available solutions to benefit both parties.

How do you prevent at least the perception by surgeons that materials managers are encroaching into their clinical domain (or telling them how to practice medicine) by 'forcing' them to change brands (due to a GPO contract, etc.) from their favorites, implement demand-matching initiatives, etc.?

If materials managers are trying to restrict access to products in hopes of reducing costs, they are infringing on the physician's ability to practice medicine and to select products they feel best meet the needs of their patients. A better approach is to get physicians to take control of the process by evaluating and reviewing product selection and reviewing accurate data on individual financial performance. In other words, when physicians are given accurate data on how their per-case costs vary relative to their peers, they will usually

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make changes to improve their performance. Similar results can be expected in demand matching programs. The key, again, is to identify and implement appropriate incentives for the doctors to participate with the hospital so they benefit from the outcomes of their efforts.

How do you recommend materials managers handle it when physicians try to 'subvert' materials management's cost-cutting efforts by using the bargaining tactic that they bring in patients, which translates into revenue?

Procedure-based physicians are the engine that generates much of the revenue in most acute care hospitals. The best way to handle conflicts created by attempts to reduce cost is to avoid an adversarial relationship and to develop programs which align incentives between the hospital and its medical staff.

What are some examples of incentive-aligning programs that work?

As you already know, there are informal and formal gainsharing arrangements that are being implemented in very small numbers. And certainly gainsharing hasn't shown any real success or great promise. The Surgical Implant Services (SIS) model is the one program with which we are most familiar. Physicians aggregate the device selection process and benefit financially from the reduction of implant costs in their hospitals. Price reductions from the resultant standardization for hospitals are significantly better than when compared to pricing in place prior to implementation of the SIS Group Purchasing Organization (GPO) services. Physician's compliance has been excellent in most markets, after an expected transition period, and appears sustainable. Each participating doctor is at risk financially for performance and receives ancillary income based on their investment interest in the enterprise. Models that do not recognize the primacy of the physician in controlling these markets may show short-term benefit, but have not been sustainable. We are unaware of other effective, long-term programs that have adequately addressed the incentive alignment question.

How can materials management gain control over influencing and managing physician preference if vendor sales reps are allowed into the surgical areas? What should materials management do? Cracking down on vendor access, for example, requires materials management to get physicians to play the game.

Vendor access and support is very important when dealing with complex implantable devices and should probably not be unduly restricted. Physicians need the assistance of vendors in dealing with technical aspects of the devices including accessories, instrumentation, modifications and improvements. The real issue is not controlling physician preferences, but rather reducing costs. Physicians are uniquely qualified to select devices and preserving their ability to do so is necessary for maintaining quality of care.

By cracking down on vendor access I'm not referring to unduly restricting them but controlling those who try to undermine existing vendor relationships and/or GPO contractual choices and obligations via 'back-door selling' or other unscrupulous sales tactics, such as billing for incorrect and/or unauthorized products and incorrect prices. This can have a detrimental effect on the hospital as well as the surgeons, don't you agree? What realistically can be done about it?

Vendor relationships in this market are primarily focused on the physicians. Implantation of medical devices often requires a good working relationship between the physician and the company representative due to the complexity of instrumentation, product components and other factors. Physicians are less concerned with the relationship between the manufacturer and the hospital and desire access to the full range of products and vendors in their field. The disconnect is a natural result of disassociating the clinical decision selection from the financial transaction, and unless hospitals find a way to align those two components of the market they will continue to bear high costs and conflict with both the vendors and the doctors.

Billing issues for unauthorized products and incorrect prices are operational issues that should be detected and controlled by the hospital's financial management and materials management system. This particular problem is minimized when physicians actively participate in the purchasing process, aligned with the hospital from both a clinical and financial perspective. Needless to say, the SIS model indirectly encourages compliance with hospital corporate and billing compliance plans, conflict of interest policies, etc. Simply trying to restrict physician choice to, for instance, a device formulary by imposing negative sanctions on non-compliant physicians will, however, only result in disgruntled physicians and perhaps liability issues.

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We've heard for years that doctors and surgeons have no idea of the costs involved in the products they are using. Is that still the case? Why? In today's world, what's taking them so long to understand? Why don't they have this data?

Physicians are accustomed to doing what they feel is best for their patients and cost is not usually the primary concern when selecting products. Both physicians and patients are effectively isolated from the cost of their decisions by the healthcare system of payment, including government and private insurance programs. There is no motivation for doctors to focus on this issue. Also, they frequently receive much of their information on product costs from vendors with whom they have a personal relationship. Hospitals have not often been willing or able to share cost data with doctors and usually have no effective process or forum to do so.

How then should hospitals, concerned about budget tightening, motivate doctors to focus on this issue? We're seeing a growing number of hospitals that indeed are sharing this cost data with doctors in order to reign in expenses without compromising quality of healthcare delivery.

Transparency of cost data, local data over national data, and peer-to-peer benchmarking data is a great way to get the doctors' attention, particularly if they see their departments or their individual members are far out of whack compared to others. We believe that physicians will consistently make the appropriate choices of devices for their patients in a financially responsible manner only when their incentives have been aligned appropriately with the hospitals' and when they bear some financial responsibility for those decisions. Sharing cost data is only a partial solution that will likely have a limited impact on motivating doctors, as long as the physicians have no financial responsibility or commitment to a more rational business model.

What kind of data offer more value – individual surgeon spending compared to the hospital's spending vs. peers vs. national benchmarking statistics? Why? What doesn't work?

Data is useful but must be individual and compared locally with peers to be of greatest

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value. Comparing to national benchmarks simply allows them to conclude their patients are different. We do find local data useful in encouraging physicians to make cost effective decisions, but this is a relatively minor factor compared to them having a stake in the outcome or success of cost reduction. Clinical benefits information on different products is unlikely to work when coming from MMs or hospitals. These are not sources of clinical information physicians typically look to and the perspective of focusing on cost will make such information suspect.

We've recently learned that a number of high-dollar medical device manufacturers are forcing customers to sign mandatory confidentiality agreements about the pricing they receive and that any revelation of that information to anyone – including GPOs, IDNs and peers, even for benchmarking purposes – constitutes a breach of contract. As a GPO, what's your reaction to this from a financial, operational, ethical and legal standpoint? How should hospitals react?

Manufacturers' pricing agreements are highly valuable and sensitive material, therefore, they should have some legitimate claim. However, this is clearly a bad idea. For one, hospitals are affirmatively obligated to provide certain kinds of pricing and discount information to the government in order to comply with anti-kickback requirements. So these confidentiality agreements cannot legally prevent hospitals from sharing information with the government. Further, this can only work to a hospital's disadvantage where they are unable to meaningfully compare physician preference item pricing with other hospitals or with GPOs in order to secure the best possible deals. It is bad for GPOs since it hinders their ability to effectively negotiate discounted pricing for their member hospitals, some of whom may be prohibited from sharing with the GPO pricing terms of previous or existing supplier arrangements.

We (SIS) do not feel these arrangements are reasonable and sustainable. Purchasers are under considerable financial pressure to reduce medical device costs in order to preserve their ability to offer services in a cost effective manner. Pricing comparisons are an important component of product selection, especially when physicians are involved in the process as in the SIS model. While pricing variations remain appropriate for different customers based on volume, market share, and other terms and conditions, confidentiality agreements serve primarily to protect manufacturer profitability and can reduce the value of these contracts to purchasers.

From the GPO perspective, transparency in pricing is preferable and the ability to compare pricing with other purchasers and contractors is necessary to provide value to members. Hospitals should avoid entering into these agreements from an operational and financial perspective and should seek relationships with GPOs, IDNs, etc. that can effectively compare pricing and other contract terms against different manufactures and other purchasing entities. **HPN**

Editor's Note: For more information on Surgical Implant Services LLC, visit the company's Web site at www.surgicalimplantservices.com.

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