

WORKING THE PUZZLE

Solving the Biggest Conundrum: Physician Preference Items



Spring 2010 IDN Summit and Expo

Peer-to-Peer Learning Exchange Research Report

Solving the Biggest Conundrum: Physician Preference Items

WHAT'S INSIDE

Setting the Stage	2
Emerging Solutions	3
Industry Surveys	4
Case Studies	5
Policy Recommendations	6
Session Follow-up	7
Information Resources	7

SETTING THE STAGE

Achieving cost efficiencies in physician preference items (PPIs) remains the largest challenge for supply chain professionals, and that's not likely to change anytime soon. These items—mainly implantable devices such as cardiac stents and artificial hips and knees—account for as much as 60% of a hospital system's materials spending. Absent significant change in current trends, that figure will only continue to rise. New implantable devices arrive every day—literally. In 2008, the Food and Drug Administration reported that 3,370 new items were submitted for FDA approval and that number continues to climb. In fact, by 2011, the Healthcare Advisory Board predicts that 35% to 45% of all procedures will use an implantable device.

The speed at which these items arrive, and payers' willingness to reimburse for them almost immediately after rollout, means these items often bypass many of the checks and balances of a hospital's typical purchasing process.

Payments aren't keeping up with costs: Hospital reimbursements from Medicare for total joint replacements between 1991 and FY 2008 rose 27%, while the average selling price for hip implants rose 132% from 1996 to 2006, according to Orthopedic Network News. Because most insurer payments to hospitals are determined by a contracted rate instead of incurred costs, the hospital's profit from each case depends on whether the device is purchased from a vendor with which the hospital was able to negotiate low prices, whether the device is covered by such a contract or whether it is considered a novel technology that must be reimbursed at a higher list price.

Further complicating factors are the recent aggressive efforts by some manufacturers to enforce price-confidentiality clauses for PPI contracts. These secrecy provisions prevent hospitals from revealing prices to group purchasing organizations or other third parties that help them negotiate prices and restrict hospitals' ability to fully inform surgeons on the price differentials in using specific products.

Some hospitals have more information about the price of PPIs. New York State publishes prices paid for PPIs by its three state university hospitals. The Veterans Health Administration reveals prices in response to Freedom of Information Act requests.

But this information is inherently incomplete, for the reasons mentioned above. This results in widely varying prices for comparable devices. For example, a survey by the Integrated Healthcare Association found that prices for similar hip implant devices varied from \$2,300 to \$7,300. The investment firm Sanford Bernstein in 2006 analyzed the prices of orthopedic implants in relation to the volume of cases performed at 100 hospitals. The study "revealed an unsustainable dispersion of pricing for (hip and knee implants) that is as high as three-fold and is not related to case volume." The analysts found that "less than 20% of price variability is explicable on the basis of hospital volume."

Many hospitals have fledgling programs to constrain spending, but in most situations, it appears that physicians and device makers still have the upper hand. There remains a realistic fear that physicians will take their business elsewhere. There is also inadequate data to make apples to apples comparison of similar products.

Historically, many physicians have weak ties to hospitals, but strong ties to medical device makers and distributors. Surgeons are often involved in product development with the device industry and are often given financial interests in the

companies in exchange for their assistance. More importantly, surgeons often are trained in the use of specific lines of instruments and are reluctant to switch to new vendors.

There is quite a bit of good news, however, for supply chain professionals looking to trim costs in this arena. Some supply chain experts say the economic downturn and new pressures on reimbursement have presented hospital supply chain managers with an opportunity. Doctors are more receptive to overtures to participate in campaigns to reduce operating room costs, even when it comes to physician preference items.

Health care reform could place additional pressure on physicians to play ball with hospital supply chain officials and the finance department. Reform legislation calls for new forms of cooperation in care delivery and sharing of reimbursement under Medicare through bundled payments per care episode. This will place a premium on controlling costs in order to assure profits.

EMERGING SOLUTIONS

The responses from hospitals to the problem of physician preference item costs are still in their early stages and to date are comparatively ineffective in the face of the scale of the problem, a number of studies have found. Still, the impetus for change appears to be gathering steam.

There are essentially two prevalent strategies in play today, along with a number of smaller-scale interventions:

Value Analysis Teams/Formularies

Some IDNs and systems have employed multidisciplinary teams to assess product equivalencies, a tactic that has worked quite successfully in influencing physician behavior in non-PPI purchasing. For example, pharmaceutical and therapeutics (P&T) committees, which include clinicians, pharmacists, benefits managers and hospital management, assess and compare pharmaceuticals based on efficacy, safety, relationship to outcomes and relative costs. The outcome of its process is, of course, the drug formulary.

In the PPI arena, value-analysis teams are assessing various products and determining the value added by certain product features to patients' outcomes and safety, weighed against relative costs. The processes' end game is restricting the number of choices of manufacturers from which physician preference items are purchased or the range of products that are bought for a given procedure.

The challenge is to recreate the successes of P&T Committees and drug formularies in PPI items. The fact that supply chain executives no longer think of pharmaceuticals as physician preference items is a demonstration of the opportunity at play. The P&T process has effectively taken the emotion out of the decision making process and incorporated physician needs with evidence.

There are, of course, differences between the assessment and use of pharmaceuticals and PPIs. Not only is there less research on therapeutic equivalencies for PPIs than for drugs, but also less time is needed to bring new devices to market—typically between three and five months for medical devices, compared with two years for most pharmaceuticals.

In a 2007 article on PPI strategies in the *Milbank Quarterly* (see Information Resources), Kathleen Montgomery and Eugene S. Schneller write: "The assumptions underlying this approach are (1) that a hospital's commitment to use a particular manufacturer will result in lower prices from that vendor; (2) that the chosen manufacturers will have a sufficient range of products to meet the physicians' demands for their various patients' needs; (3) that the wide range of products currently available on the market is unnecessary because there are genuine product equivalencies; and (4) that patients' safety is enhanced when the operating team uses familiar products with which they have experience, even when individual members may rotate from one team to another."

The biggest limitation to this approach is physicians' willingness to serve on the value analysis teams and/or to heed the dictates of these panels. Anecdotal evidence indicates that in many cases in the recent past, physicians have balked at any hint of a formulary, but that may be changing.

The Payment-Cap Model

Another strategy being employed by IDNs and systems is the payment-cap model. It doesn't explicitly restrict specific products or manufacturers but instead standardizes costs by establishing an upper limit on the price the organization is willing to pay for any product in a particular category and then telling physicians to use products that meet that price.

The principal assumption underlying the payment-cap strategy is that the manufacturers of similar products will compete to offer an equivalent product within a price ceiling established for that product's specification. Nevertheless, this strategy may result in restricting some choices of products if vendors decide not to meet a hospital's price ceiling and not to make their products available to that facility.

Montgomery and Schneller report that the payment cap model draws on the hospital's contracting power and control of access to the facility. They say that hospitals that use a payment-cap strategy report success with a "tough love" policy for vendor pricing, quoting a director of surgical services at one hospital: "We set a price ceiling—a capitated rate—and told recalcitrant vendors 'forget it.' Ultimately, they came to the table."

The authors of the study, who have written extensively on PPI issues, write that most facilities have adopted value analysis teams, but argue that the payment cap model is gaining steam.

In both the above strategies, physicians are often incentivized to cooperate/participate. Some systems pay physicians for their time serving on value-analysis panels. Others sweeten the deal through investing in improved surgery facilities and staff and developing a surgery service line to give physicians a competitive leg up.

Other Strategies

Eighty-four percent of California hospitals surveyed by the Integrated Healthcare Association now share prices with physicians, making this the most used PPI best practice in that state.

UnitedHealth Group has a program called the UnitedHealth Premium physician designation program, whereby physicians are evaluated on quality and cost-efficiency criteria, including product use. High scores lead to fee-schedule enhancements.

Finally, there is gainsharing. Since physician cooperation is needed to manage medical devices, a natural hospital strategy would be to share with physicians any resulting financial savings. Medicare in general prohibits this practice out of concern that an interest in reducing costs could create financial incentives for physicians to reduce the quality of care. Proposals by the Medicare Payment Advisory Commission to modify or eliminate the ban on gainsharing have gone nowhere.

INDUSTRY SURVEYS

A number of research surveys have traced the use of various PPI strategies. The most recent analysis was conducted by IDN Summit and Expo and released in February 2010. We mailed a survey to 728 healthcare executives of various aspects of supply chain management at integrated delivery networks and health systems across the United States, and 139 responded. Ninety-three percent of respondents identified PPI as an area of strategic importance.

Value analysis teams were the most commonly implemented PPI strategy cited by respondents, with 73% having already adopted it and 18% strongly considering doing so.

Fifty-five percent of respondents had adopted the payment-cap model, and another 20% were strongly considering it. However, just 27% of respondents had gone as far as adopting a formulary. Another 36% were considering doing so. In June 2009, the journal *Materials Management in Health Care* and the Association for Healthcare Resources & Materials Management published a survey of 570 hospitals on PPI. It found that more hospitals were turning to some form of PPI standardization. Nearly 75% of respondents either had a strategy for standardizing PPI already in place or were working on one.

About 64% of hospitals surveyed were using value analysis teams to ensure that products are appropriate and achieve good clinical outcomes, and 45% of value analysis teams had physicians involved in the process.

The survey also found that 46% of respondents were limiting the number of manufacturers from which physicians could choose, and 45% were imposing price ceilings for particular item categories.

Finally, the Healthcare Financial Management Associations' 2008 Supply Chain Survey asked 225 supply chain and financial leaders to identify strategies that pose greatest opportunity for garnering physician and clinician buy-in to supply chain savings. The top three ranked as "high" or "tremendous" opportunities were:

- Engaging the physician executive team in the development of a supply chain strategic plan with clear goals and accountabilities (51%)
- Sharing data with physicians to increase their awareness (50%)
- Conducting value analysis (49%)

CASE STUDIES

The Health Sector Supply Chain Research Consortium at Arizona State University has studied emerging efforts undertaken by IDNs and systems to address physician preference item management. It examined four systems that had innovated in one area of PPI strategy.

Here is a brief synopsis of the consortium’s report (see Information Resources):

HCA–West Florida

HCA–West Florida, part of a healthcare system of 15 affiliated hospitals and six surgery centers, launched an “internal sales force” initiative staffed by former supplier representatives who support working relationships among hospitals, physicians and their office staffs. The strategy focuses on increasing volume and efficiencies in specific clinical service lines, including orthopedics. Team members evaluate efficiency in the operating room and inpatient service, help identify problems and facilitate change. The physician gains a voice in the hospital, identifies business opportunities and increases volume of practice. The hospital increases volume of business, lowers costs and develops a partnership with physicians and a competitive position. Overarching characteristics of the internal sales force are a strong understanding of what is valuable for orthopedic surgeons in their practice and the ability to recruit former implant sales representatives as team members.

New York–Presbyterian Hospital

The five-hospital New York–Presbyterian Hospital in New York City, which is affiliated with two medical schools, has developed a procurement and strategic sourcing team with product-line specialization. Its process involves disciplined engagement of physicians with fact-based information pertaining to costs and use.

The team (composed of a physician leader and managers with strong business backgrounds) uses a variety of approaches to PPI cost control, including:

- Counter-detailing: The team provides publicly available data on product pricing and supplier profit margins to counter the information provided by suppliers.
- Clinical crosswalks: For requests for proposals, these are used as a means to compare different supplier prices for clinically similar items.
- Scenario-based sourcing. Here different scenarios are incorporated into the RFP, which requires vendors to bid on different outcomes.

“NYP’s approach is data-driven, maintains business-style professionalism, and focuses on physicians as clinical partners,” the Health Sector Supply Chain Research Consortium report finds. It also depends on strong leadership and administrative support, successful use of data, and a high level of respect and accountability in relationships with physicians.

Sisters of Mercy Health System

Sisters of Mercy Health System is an IDN that has developed a home-grown group-purchasing organization—Resources Optimization and Innovation (ROi), which has a distribution system serving 18 acute-care hospitals, two cardiac hospitals, and managed care organizations in Arkansas, Kansas, Missouri, and Oklahoma. ROi strives to develop sustainable partnerships with physicians practicing in the system.

ROi has a total joint replacement initiative that makes strong use of data and involves a great deal of clinical collaboration. Strategies used in contracting include establishing a percentage off list price, price caps, risk sharing, vendor consolidation and reimbursement ratios. The initiative has had estimated cost savings of \$1 million.

“Valuable lessons learned include the following: vendor compression saves money and reduces variability; the success of a strategy is dependent on physicians’ buy-in; and physician leadership leads to greater success. ROi/SM’s uniqueness is attributable to its efforts to bring together a wide variety of supply chain–management functions under its own roof,” the Health Sector Supply Chain Research Consortium report finds.

Nebraska Orthopaedic Hospital

An acute care orthopedic specialty hospital located in Omaha, Nebraska Orthopaedic is a joint venture between Nebraska Medical Center and group of orthopedic surgeons. It has dual-source contracts for total joint replacements with mandated compliance, use of on-site vendor representatives to encourage on-contract product use, price caps for basic implants, regular meetings with physicians and extensive use of IT.

Nebraska Orthopaedic limits the number of vendors and carries no inventory. These strategies have resulted in average supply cost for a total knee replacement that is half that of other area institutions with similar volumes.

Its efforts also are succeeding because of strong administrative support and involvement, focus on the physician as customer and data-driven decisions. The strategies are enabled through a focused approach as a specialty hospital and its joint-venture status with an elite academic medical center.

Another case study of PPI success is found in HCA's TriStar division, which developed a capitated agreement for spinal implants in April 2008. "We set the market rate we were willing to pay and worked through it from that perspective," Jay Kirkpatrick, president of the Association for Healthcare Resources & Materials Management and CEO of HCA's Nashville Supply Chain Services, told *Materials Management in Health Care* in June 2009. Already, more than 80% of TriStar's spinal implant spending is covered under the agreement, and the organization is working to get everyone to comply.

POLICY RECOMMENDATIONS

A number of national solutions have been suggested for controlling PPI supply costs by various health policy experts and supply chain professionals. They include:

A National Medical Device Council

Such a council would perform systematic reviews of existing research, perform technology assessment, focus on clinical evidence and cost-effectiveness data, identify gaps in knowledge, store information in an easily accessible database and provide continuous assessment. A number of public and private agencies currently perform some of these duties including the Agency for Healthcare Research and Quality's Evidence-Based Practice Centers, the ECRI Institute, Tufts Medical Center's Cost-Effectiveness Analysis Registry, the Blue Cross/Blue Shield Technology Evaluation Center and the HMO Research Network. One entity does not perform all tasks, nor are data easily accessible in every case.

A National Joint Registry

Implant use, outcomes, and longevity would be tracked via this registry. Long-term outcomes data would be amassed to evaluate the comparative effectiveness of various orthopedic implants. Kaiser Permanente developed a national total joint replacement registry in 2001. Data from this registry have shown a 10% difference in revision rates between partial and total knee replacements, leading to reduction in partial knee replacements and savings of \$550,000.

A National Implant Price Registry

Increased transparency of information related to price would allow hospitals, payers, and ultimately patients to make better-informed, value-based decisions. There have been several efforts in the U.S. Senate to establish a national implant registry. One bill, sponsored by Sen. Charles Grassley (R-Iowa), would require manufacturers to report average and median selling prices of all implantable devices. Required quarterly reports from manufacturers on sales price data would need to include volume discounts, cash discounts, charge-backs, rebates and any other discounts.

Gainsharing

This would encourage greater collaboration between hospitals and physicians in evaluating the comparative effectiveness of implants. Formal gainsharing arrangements between hospitals and physicians have been tested in cardiology and cardiac surgery. A recent study on gainsharing in cardiology, funded by the Health Sector Supply Chain Research Consortium, found that hospitals reduced costs by 7.4% through such programs, mainly from lower prices.

The main obstacle to date in gainsharing has been strict regulations and difficulty in obtaining a favorable opinion from the U.S. Department of Health and Human Services' Office of the Inspector General.

The Centers for Medicare and Medicaid Services has proposed demonstration projects related to implant replacement procedures that may provide more support for gainsharing and potentially lead to relaxed regulations.

Clinical Effectiveness Research

Some \$1.1 billion was allocated through the American Recovery and Reinvestment Act of 2009 to support comparative-effectiveness research into treatments, drugs and medical devices. The law also established the Federal Coordinating

Council for Comparative Effectiveness Research, charged with developing a framework of healthcare comparative effectiveness for the government to help determine where the money should be spent.

As part of the health care reform efforts, both House and Senate bills would establish a more robust comparative effectiveness institute to assess the comparative effectiveness of drugs, devices and care processes. If prices became more transparent, policymakers, health professionals, provider organizations and consumers could assess the cost as well as the clinical effectiveness of competing devices.

Conflicts of Interest

There has been considerable interest in Washington in the effect of surgeons' financial ties to medical device manufacturers. There have been congressional hearings on the issue, and the Justice Department in 2007 negotiated a settlement under which five manufacturers of orthopedic implants now report their payments to individual physicians on their websites. In addition, a number of academic medical centers have pressed for stronger regulation and transparency in physicians' supplier relationships.

SESSION FOLLOW-UP

The Physician Preference Item (PPI) breakout session was well attended and a lively discussion. All participants shared of their successes and frustrations at their local institutions. Generally speaking the two oft quoted keys for success was physician engagement and Senior Leadership support.

INFORMATION RESOURCES

- "Hospitals' Strategies for Orchestrating Selection of Physician Preference Items," The Milbank Quarterly, Spring 2007 <http://www.ncbi.nlm.nih.gov/pubmed/17517118>
- "Making the top-tech list; Using comparative-effectiveness research and best practices, hospitals hope to save money while improving quality of care," Modern Healthcare, July 21, 2009 <http://www.modernhealthcare.com/article/20090720/REG/907169983>
- Engaging Physicians for Supply Chain Savings, HFMA Educational Report, 2008 www.hfma.org/NR/rdonlyres/.../400649SupplyChainSavingsAmerinet.pdf
- Physician Preference Item Management Informational Guide and Self-Assessment Tool, Health Sector Supply Chain Research Consortium at Arizona State University http://wpcarey.asu.edu/healthcare-anagement/consortium/upload/PPIM_Assessment_Tool.pdf
- "Hip And Knee Implants: Current Trends And Policy Considerations" Health Affairs, Nov./Dec. 2008 <http://content.healthaffairs.org/cgi/content/abstract/27/6/1587>
- "The Consequence Of Secret Prices: The Politics Of Physician Preference Items," Health Affairs Nov./Dec. 2008 <http://content.healthaffairs.org/cgi/content/abstract/27/6/1560>
- "Value-Based Purchasing For Medical Devices," Health Affairs, 27, Nov./Dec. 2008 <http://content.healthaffairs.org/cgi/content/abstract/27/6/1523>
- "Your Strategy for Continuous Supply Savings," Healthcare Financial Management September 2009 http://www.hfma.org/library/accounting/costcontrol/400670_SupplySavings_EduRep.htm
- Engaging Physicians for Supply Chain Savings, Healthcare Financial Management Association Educational Report <http://www.hfma.org/library/accounting/costcontrol/400649.htm>
- "Preference matters," Materials Management in Health Care; February 2010 http://www.matmanmag.com/matmanmag_app/jsp/articledisplay.jsp?dcrpath=MATMANMAG/Article/data/10OCT2009/0910MMH_Coverstory&domain=MATMANMAG

The logo consists of a circular emblem on the left containing a stylized, swirling 'S' shape. To the right of the emblem, the text 'IDN SUMMIT' is written in a large, bold, sans-serif font. Below 'IDN SUMMIT', the words 'AND EXPO' are written in a smaller, all-caps, sans-serif font.

IDN SUMMIT
AND EXPO

2201 Regency Road Ste. 302
Lexington, KY 40503
859-523-5701
www.idnsummit.com