2010

HEALTH REFORM AND THE SUPPLY CHAIN

IDN SUMMIT AND EXPO

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INTRODUCTION

The Patient Protection and Affordable Care Act of 2010 – more commonly known as health reform – will affect nearly every aspect of the U.S. healthcare delivery system. While many provisions of the law roll out incrementally over a period of several years, taken together, they will push providers to collaborate more than ever before as they focus intensely on the quality, efficiency and safety of patient care. More immediately, a wide range of reimbursement cuts will find most providers scrambling for new means of achieving savings in order to remain profitable.

Many of these changes have special resonance for the hospital supply chain department. Supplies, including medical devices such as knee implants and pacemakers, as well as medications and surgical packs, have exploded in cost and now account for perhaps a third of a hospital's expenses on a per-case basis. The safety, efficacy and cost-efficiency of the care provided by America's hospitals depends in part on decisions made by supply chain professionals working in tandem with physicians and hospital administration.

This is an optimal time, then, to take the pulse of the supply chain profession in regards to the likely impact of health reform. This report details the responses of 200 senior healthcare supply chain professionals at integrated delivery networks and health systems across the U.S. to an e-mail survey conducted by IDN Summit and Expo earlier this summer. These senior executives tend to represent organizations with more than 500 beds, placing them in the top tier in terms of size and dollars spent on supplies annually.

This is the second installment of an ongoing research project aimed at providing a better understanding of factors impacting the healthcare supply chain. The first report, published in March, had 139 responses. It looked at a range of issues, including health reform, which at that point had not taken final shape in Congress. At that time, 73% of respondents said they were "extremely concerned" about the potential effects of reform. Those concerns were borne out by the final legislation, which indeed has far-reaching implications for the supply chain.

The IDN Summit Research Series is an on-going research project to provide a better understanding of the links in the healthcare supply chain. This research will provide key insights to foster an improved healthcare supply chain and identify key trends impacting the industry. To participate in future research please contact Lisa Ponssa at lisa@idnsummit.com or call her at 813.928.0414.

WORRIES OVER REFORM

"It is positive that more people will be covered, but the concern is at what reimbursement rate? Continuing to find cost efficiencies will be an imperative, while being committed to not compromising the quality of care delivered."

"I believe the process in place today will primarily lead to reduced reimbursement and increased costs."

– Written comments from survey respondents

Though they see some positives in reform, in general respondents were not optimistic about the new law's overall impact on their operations and organizations, as well as the health system as a whole.

When it comes to the healthcare supply chain, reform will be:

- [ ] A net positive 18%
- [ ] Neutral 11%
- [x] A net negative 49%
- [ ] Unable to determine 23%

The largest concern appears to be financial. Hospitals will experience a total of $155 billion in Medicare payment reductions over 10 years, the result of a deal that the hospital lobby made with the Obama administration last year in exchange for its support of health reform. Hospital disproportionate-share (DSH) payments for both Medicare and Medicaid will be cut starting in fiscal year 2014 to reflect the lower numbers of uninsured. For Medicaid alone, total DSH payments will be cut by $14.1 billion from 2014 to 2020.

Almost every provider of care will be subject to pay for performance under Medicare and Medicaid, under which a portion of payment is withheld and providers can earn back full reimbursement by showing the greatest improvement or having the highest scores on measures of clinical quality and patient satisfaction. For example, hospitals will take part in a value-based purchasing program for Medicare beginning with discharges occurring on or after Oct. 1, 2012. Hospital base payments would be reduced by 1% in 2012, gradually rising to 2% by 2016.

Beginning with discharges on Oct. 1, 2012, inpatient hospitals will have their payment reduced based on their potentially preventable Medicare readmissions for three conditions endorsed by the National Quality Forum and for another four measures to be identified by the Medicare Payment Advisory Commission. Other measures may be added in the future.

And beginning in fiscal 2015, hospitals in the top 25th percentile of rates for hospital acquired conditions for high-cost and common conditions are subject to an additional payment penalty of 1%. Data would be made public on the Hospital Compare website. HHS must submit a report to Congress by Jan. 1, 2012 regarding possible expansion of this program to other care settings.

Perhaps just as significant a development will be an Independent Medicare Payment Advisory Board, which will be established to develop and submit proposals to Congress aimed at extending the solvency of Medicare, slowing cost-growth, improving quality of care and reducing national health expenditures. Its proposals will be automatically implemented unless Congress acts in opposition; its proposals will be effective for hospitals starting in 2020.

For the U.S. healthcare system as a whole, reform will be:

- ❑ A net positive 26%
- ☑ A net negative 50%
- ❑ Neutral 4%
- ❑ Unable to determine 20%

Respondents were not sanguine about a huge new pool of paying patients that will be available in 2014, when as many as 19 million uninsured people will find coverage as a result of the law. (A total of 32 million uninsured will wind up being insured.) Over time, that should greatly reduce hospital and medical practice costs for charity care and bad debt as well as unreimbursed emergency care.

And respondents were particularly concerned about the potential impact of a new excise tax on the sale of medical devices by the manufacturer or importer equal to 2.3% of the sales price. The tax has the potential to increase hospital costs, many respondents said.

Level of concern over aspects of reform:

	Extremely concerned	Moderately concerned	Unconcerned
Reduced reimbursement	93%	7%	0%
New excise of 2.3% on medical devices	63%	29%	8%
Long-term impact of commercial payer contracting strategies	62%	30%	8%
Payment reductions for preventable readmissions	55%	38%	7%
Payment reductions for healthcare-acquired conditions	54%	40%	6%
Pay for performance under Medicare and Medicaid	53%	37%	10%
State and local regulations as result of national reform	53%	39%	9%

	Extremely concerned	Moderately concerned	Unconcerned
Higher mandatory utilization rate for advanced diagnostic imaging	52%	40%	8%
Long-term impact of comparative effectiveness research on reimbursement	42%	46%	12%
Required disclosure of financial relationships between vendors and health providers	34%	29%	37%
Mandatory compliance programs	33%	37%	30%

The new excise tax on the sale of taxable medical devices will:

☑ Place a greater emphasis on controlling device costs in the hospital	46%
❑ Simply be passed on to consumers and have little hospital impact	37%
❑ Not be a significant factor	5%
❑ Don't know	12%

AREAS OF OPTIMISM

"Healthcare reform will provide numerous opportunities to improve our supply chain model. We will be challenged to meet these opportunities by thinking broader than our otherwise normal processes. While risks are higher, inaction is terminal."

"Reduced reimbursement will continue to place emphasis on cost reduction of supplies, labor and services while continuing to increase quality. (Healthcare organizations) that do not prepare for these changes will be forced to make irrational decisions to continue to remain in operation."

– Written comments by survey respondents

Respondents did see some silver lining in the dark cloud of reform. Despite their overall negative view of reform, respondents believe that new programs that encourage physicians and hospitals to work more closely together – including accountable care organizations and bundled payments per episode of care – could have significant positive impacts for healthcare. They also pointed to expanded rebate programs to make prescription drugs less expensive. In 2011, pharmaceutical manufacturers whose drugs are covered under Medicare Part D must provide a 50% discount for brand-name drugs, and a generic drug discount in the form of a federal subsidy is also provided to eligible beneficiaries beginning in 2011.

They also see the benefit of new support for primary care. Under the law, Medicaid payment rates to physicians providing primary care services must equal at least 100% of the Medicare payment rate in 2013 and 2014. The federal government will fund the cost of this requirement. Select primary care services and general surgeons providing care in health professional shortage areas will receive a 10% Medicare payment bonus, effective in 2011.

Importance of areas of opportunity in reform:

Solution	Very important	Somewhat important	Not important
Incentives for hospitals and physicians to collaborate on patient care	77%	21%	2%
Greater comparative effectiveness research	69%	29%	4%
New funding for health IT	66%	33%	3%
Higher payments for primary care	63%	34%	3%
Reduction in ER care from fewer uninsured	56%	38%	6%
Increased rebate for generic drugs	51%	42%	7%
New rebate formularies on brand name drugs	47%	43%	10%

Interestingly, respondents think that the added pressure on costs will have the effect of increasing the importance of the supply chain department within a health system.

Cuts in reimbursement will:

☑ Enhance the role of the supply chain department:	88%
❑ Diminish role of the supply chain department:	3%
❑ Have little to no effect:	4%
❑ Don't know:	4%

CONTROLLING COSTS IN THE ERA OF REFORM

"The direction of the specific reform activities currently in process will likely put increasing pressure on indirect and variable cost controls, and may enhance clinician support of more effective clinical value analysis and standardization efforts."

"I am concerned that health care reform will mostly be a payment reform system that does not address some of the major issues that increase cost that hospitals and doctors have no control over. An example is malpractice reform."

– Written comments by survey respondents

Given the nature of reform, respondents see a key role for their departments to act quickly to control runaway healthcare spending. They place particular emphasis on physician preference items, chiefly big-ticket medical devices over which physicians have significant influence. Health systems have made heroic efforts to standardize the use of certain devices, but physicians often balk at those efforts, either because they are used to using a specific product or have ties to the manufacturer of the product. Many respondents think the pressure of reform will help them finally gain sufficient leverage to influence physician preference and bring physicians into the process of evaluating various devices for cost-effectiveness.

Importance of supply chain efficiencies to address costs post-reform:

Solution	Very important	Somewhat important	Not important
Controlling supply spending	93%	7%	0%
Managing supply utilization	93%	7%	0%
Reducing physician preference item spending	91%	8%	1%
Reducing drug and other non-supply direct spending	85%	13%	2%

Solution	Very important	Somewhat important	Not important
Supply chain automation	77%	21%	2%
Implementing industrywide standards (e.g., GS1)	69%	28%	3%
Optimizing supply chain labor	64%	30%	6%
Managing supply chain inventory	63%	31%	6%

Among the many cost reduction elements of the reform bill is an attempt to reduce the spread of imaging services. The utilization rate assumption for calculating the payment for advanced imaging equipment would increase from 50% to 75%, effective in 2011. That is, imaging facilities that aren't booked 75% of the time will lose out. Physicians must disclose ownership interest in imaging equipment to their patients, effective later this year.

ACCOUNTABLE CARE ORGANIZATIONS

The impetus of accountability and coordination of care between hospitals and medical groups drove the inclusion of accountable care organizations in the law. Eligible organizations would be groups of providers and suppliers that have an established mechanism for joint decision making, including practitioners in group practices, networks of practices, partnerships or joint ventures between hospitals and practitioners, hospitals employing practitioners, and others. These groups would be eligible to take part in the new Medicare Shared Savings Program, which will be implemented by Jan. 1, 2012. Organizations that meet quality targets and reduce costs relative to spending benchmarks are rewarded with a portion of the savings. HHS will establish the measures used to determine whether an organization can share savings, such as clinical outcomes, patient experience of care and utilization rates.

Again, respondents think that this reform holds great promise for achieving needed savings.

Accountable care organizations after organization:

- [x] Represent a major opportunity to reduce costs — 48%
- [ ] Are a major opportunity to improve hospital margins but aren't directly associated with supply chain operations — 20%
- [ ] Will have little to no effect on supply chain operations — 16%
- [ ] Don't know — 16%

BUNDLED PAYMENT

Another innovation in the reform legislation is known as bundled payment. A pilot program will test whether hospitals, physicians and post-acute-care providers will be able to share a single payment for coordinating an episode of care from first office visit to end of post-acute care. The Department of Health and Human Services will select eight conditions to be included in the pilot, which starts in 2013. If it is successful, HHS can roll out bundling nationwide after Jan, 1, 2016, without congressional approval. A bundled payment demonstration program under Medicaid would be established, with HHS awarding grants to the states.

In general, respondents were fairly positive about the potential of bundled payments, as the chart indicates.

Bundled payments per episode of care will:

	Agree	Neutral	Disagree	Not sure
Engage physicians to collaborate with the value analysis process on product selection	79%	5%	8%	6%
Change the contracting model from category to procedure-based	70%	12%	7%	12%
Reduce payments hospitals make to doctors by the price differential in the "preferred" vs. "non-preferred" product	68%	12%	14%	6%
Have little to no impact on a physician's product choice	33%	3%	59%	5%

COMPARATIVE EFFECTIVENESS RESEARCH

The reform law includes authorization and $10 billion in funding for a new Patient-Centered Outcomes Research Institute, which has already been established to identify national priorities for comparative clinical effectiveness research. Neither the institute nor HHS can mandate coverage or reimbursement policies based on the institute's research.

Respondents were not optimistic that the institute's output will be a game-changer when it comes to pushing physicians to become full partners in the effort to control supply spending on physician preference items. But respondents did think that the data will help them as they evaluate new products and seek value.

The work of the Patient-Centered Outcomes Research Institute will:

	Agree	Disagree	Neutral	Not sure
Not fundamentally change involvement of MDs at system level in evaluating products	81%	10%	7%	3%
Result in higher-priced items remaining the best choice because of superior outcomes	77%	11%	9%	3%
Provide a new source of data to help supply chain managers evaluate products and seek value	74%	11%	12%	4%
Take years to come up with definitive findings in many areas of clinical complexity	66%	16%	12%	7%
Influence physicians' clinical practice decisions	59%	19%	18%	5%
Have a direct and immediate effect on reimbursement	56%	15%	21%	7%
Have no impact on supply costs/spending	35%	46%	15%	6%

ENHANCED INTEGRITY PROVISIONS

The bill seeks to uncover financial relationships that carry the potential of conflict of interest in product choice. It requires disclosure of financial relationships between health entities, including physicians, hospitals, pharmacists, and other providers, and manufacturers and distributors of covered drugs, devices, biologicals, and medical supplies. One of the more significant problems that supply chain departments confront in attempting to reduce spending and streamline procurement processes are physicians' financial ties to vendors, especially medical device makers.

Respondents were split on the impact of this provision, but more than fourty percent said it has the potential to reduce costs. Thirteen percent said it has the potential to increase costs because of the added burden of having to patrol physicians' financial activities.

New financial disclosure rules will:

☑ Reduce costs as hospitals take action to ensure physicians don't have a conflict	22%
❑ Reduce costs as physicians seek to avoid the appearance of a conflict	21%
❑ Have little or no effect as patients are seldom aware of conflicts	19%
❑ Increase costs based upon an elevated burden to managed COI regulations	13%
❑ Have the potential to further shift research "innovations" overseas	9%
❑ Don't know	13%

CONCLUSION

Reviewing the many written comments of respondents, one word keeps coming up – "concern." It could just as easily have been "anxiety"; the uncertainties of reform clearly have supply chain professionals on edge.

Many took time to make extensive comments, including thoughtful critiques of the reform law and philosophical remarks about the value of expanding access to care for more Americans. Others think the new law is anything but reform, and some said they are waiting to see if portions of the law are repealed.

Still others think the jury is still out. "Most of the rules are still to be written," one wrote.

"So much is unknown today, and keeping up to date is essential as the bill today will look much different when implemented," wrote another.

That's perhaps as fitting a conclusion as any.

IDN SUMMIT AND EXPO

About IDN Summit and Expo

Since its creation in 1986, IDN Summit and Expo has become the leading source of collaborative networking events, education and information resources and professional services for healthcare supply chain stakeholders. It focuses on best practices, enhanced communication and improved business processes that lead to more cost-effective patient care. The spring and fall summits bring together senior healthcare executives and their group purchasing organization and supplier partners in an open, learning environment. The meetings have as their foundation a range of strategic content developed by an independent Educational Advisory Board made up of senior integrated delivery network executives. Additional information may be found at www.idnsummit.com.

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