Losing preferential treatment

Physicians face limited choice in medical device selection as hospitals push to slash supply-chain costs

Skaneateles Falls, NY February 15, 2013 Gagged by their supply contracts, some hospitals have devised a simple way to educate physicians about the cost of pricey implants: using color-coded stickers to indicate the level of a device's price.

Many of these hospitals are barred by confidentiality clauses with device manufacturers that limit, in some instances, whether hospitals in the same health system can share pricing data about the devices they purchase. Instead, they mark the devices with colored tags specifying high-, medium- or low-cost options.

The widespread use of confidentiality clauses—which limit price transparency and hospitals' ability to shop for devices based on price—and longstanding relationships between physicians and device companies are the two major factors driving costs higher on implantable devices such as artificial knees and hips or cardiovascular stents, which are among the most expensive items hospitals buy. They are frequently called physician preference items because orthopedic and cardiovascular surgeons traditionally make the final decisions as to which devices a hospital will use. Only over the past five years or so have some hospital administrators started to implement strategies to reduce the costs of these items.

However, mounting pressure on hospital margins, the increasing number of physicians employed by hospitals and the shift to new payment models that align the financial priorities of hospitals, physicians and a patient's cost of care indicate that the concept of a physician's preference may soon be a thing of the past.

“This will be an area where there is a lot of opportunity for cost containment because it's an area that has really run rampant in the past and has not been well controlled by many hospitals,” says Dr. Kevin Bozic, vice chairman of orthopedic surgery at the University of California at San Francisco. “There's not as much flexibility and fat in the system. They're going to have to be much more efficient and function with the same discipline as other businesses.”
At the same time, the costs of many implantable device procedures continue to rise. Orthopedic procedures accounted for most of the growth in Medicare implantable device procedures from 2004 to 2009, with spending on those procedures increasing 8.1% annually for five years, according to a Government Accountability Office report from January 2012.

There is little publicly available data showing the individual prices of implantable devices and whether those prices are rising. But the same report found examples of “substantial price variation,” with one hospital paying $4,500 for a specific primary total hip construct and another paying $8,000 for the same product.

“The cost of joint implant constructs used for knee and hip replacement vary widely and are major contributors to the variation in the cost of care for patients undergoing total joint replacement,” according to a separate study published last year in the Journal of Bone & Joint Surgery.

With hospital margins under pressure, many large health systems and integrated delivery networks have become increasingly aggressive about implementing cost-cutting initiatives that target medical devices. They usually focus on reducing prices and the number of manufacturers—which can lead to better volume discounts—as well as seeking better utilization practices. Hospitals have introduced gain-sharing programs that allow physicians to share in cost savings. They're also creating device registries that track performance to help inform purchasing decisions and instituting bundled-payment models that may also reduce costs and improve quality.

However, there are no specific efforts under way to ban the use of confidentiality clauses.

Jeffrey Lerner, president and CEO of the ECRI Institute, an independent health technology assessment organization, says that increased awareness of the clauses, as well as the ongoing cost pressures and market changes, could lead to increased pricing transparency.

But there's more to reducing a health system's supply costs than just addressing price, says Brent Johnson, vice president of supply chain and imaging services and chief purchasing officer for Intermountain Healthcare, Salt Lake City. There is greater financial benefit when Intermountain better manages utilization and standardizes practices rather than solely focusing on price, he says.
“In this industry, we tend to tiptoe around physicians. That they are allowed preference is a huge conflict of interest most of the time,” Johnson says. “When the physician has a choice between keeping his loyalty and whatever benefit he gets from the vendor and keeping his salary whole, he'll abandon the preference in a minute.”

Many physicians develop preference for specific devices or manufacturers early in their careers. In a fee-for-service model, physicians have little incentive to choose less-expensive devices and more often than not their interests are closely aligned with those of the manufacturer rather than the hospital. This is changing.

“There have been more attempts to align the interests, financial or otherwise, of hospitals and physicians,” UCSF's Bozic says. “More physicians are employed by hospitals; more physicians are entering into joint ventures or co-management agreements with hospitals; and newer payment methodologies such as bundled payments are effectively putting both the hospital and the physicians at risk for the cost of care, (which) aligns their incentives around improving quality and reducing costs.”

The Affordable Care Act is at the center of many of these changes. Along with the introduction of new payment models, such as accountable care organizations and patient-centered medical homes, the inclusion of the Physician Payments Sunshine Act is expected to make the financial relationships between physicians and manufacturers more transparent. Under the Sunshine Act, device companies are required to collect data about the payments, gifts and other “transfers of value” they give to physicians. That data will be posted online beginning in September 2014, which might give hospitals and physicians an incentive to reduce the appearance or prevalence of certain relationships.

“That level of disclosure may be operating to weaken the bond between the implanting surgeon and the company,” ECRI's Lerner says.

In fact, physicians are increasingly getting involved with supply chain-led initiatives to reduce costs. Dr. Richard Parker, chairman of orthopedic surgery at the Cleveland Clinic, has been working closely with the 11-hospital system's supply-chain staff since 2008. Parker, a sports medicine surgeon, was named chair of orthopedic surgery in 2009. “When I moved into that leadership role, I became much more acutely aware of costs,” he says.
With the move toward what Parker calls “value-based medicine,” physicians are becoming more engaged in supply decisions, especially in the cases where a change in device can affect patient care or when the price of a device makes up a large percentage of certain DRGs. He says there is little pushback from other physicians who may question some standardization efforts.

“We attract individuals who, quite frankly, value the brand of the organization more than their individual brand,” Parker says. “They realize that in order for this to continue we have to get our arms around these things.”

At Intermountain, the doctors who are members of physician preference committees for orthopedics, cardiovascular, neurology, trauma and surgical services items are “already more engaged, accepting of change and know this is where we're headed,” Johnson says.

The first time the supply-chain team tackled the costs of orthopedic devices was in 2007, when the 21-hospital system was spending about $32 million annually on that device category alone.

That same year, Johnson received approval from the system's administrators to share up to 30% of documented first-year savings on the costs of orthopedic devices with the system's orthopedic surgeons. By supporting Intermountain's strategy to implement standard pricing policies—physician support pressured suppliers to comply—the physicians could use the savings to purchase other equipment, supplies or training.

The approach worked, and Intermountain now re-evaluates the cost of physician preference device categories every two years. The average savings for every category assessment is about 20% each time, Johnson says.

However, he views many of the pending payment reforms as the potential forces in driving the concept of “preference” out of the industry. If a physician has to take a 20% deduction on the cost of a procedure or agree to use a limited number of suppliers, the physician will be more likely to support standardization, Johnson says.

“Healthcare reform isn't just about cost. We've got to manage utilization,” he says. “We need physicians and surgeons to not just be loyal to one supplier, we need them on board to help us manage utilization and standardization and value beyond just price.”
So while market and regulatory change may be coming, it may not be occurring as quickly as some hospitals would like. Physician preference items are usually among a hospital's most expensive supply costs. With few organizations willing to make further cuts to labor costs—an organization's highest expense—they are instead focusing on reducing their second-largest expense—supplies—with physician preference items being a key target.

“Nonlabor (cost) is now getting a lot of attention because we squeezed everything we can out of the labor side,” says Ed Hardin, vice president of supply chain management for Christus Health in Texas. “We can't afford to make those kinds of cuts, so we've got to get more efficient and more effective about how we run our supply chain.”

Physician preference items account for about 57% of total supply costs for Christus Health, Hardin says, a percentage that has increased 10% since 2008. “It's rising as a percentage of total supply expense, whereas commodity spend has gone down,” he says.

As the cost of physician preference items continues to make up a larger percentage of total supply costs, some hospital systems have looked outside of their networks in an effort to better address the costs of these devices.

Cleveland Clinic and Dignity Health, both large health systems, have formed separate joint ventures that specifically aim to address the costs of physician preference items.

San Francisco-based Dignity Health developed a for-profit company called SharedClarity with UnitedHealthcare and up to 10 additional and unnamed health systems.

“These organizations are combining data to help inform healthcare organizations about the best-performing medical devices through comparative effectiveness studies,” according to SharedClarity's website. “For the first time, these exclusive studies will enable doctors and administrators to make informed decisions based on clinical proof rather than manufacturer influence.”

When the Cleveland Clinic announced its joint venture with VHA this month, it stressed that it will focus on how it can reduce the costs of physician preference items for its hospitals. However, there are also plans to bring in VHA members, Cleveland Clinic affiliates and other organizations.
The Greater New York Hospital Association recently received approval from the U.S. Justice Department to establish a voluntary gain-sharing program for its member hospitals. UCSF's Bozic says the university is looking into the possibility of developing a similar program.

ECRI's Lerner says more hospital systems will form partnerships or other ventures to help them rein in the costs of these devices. “Change brings a lot of experimentation,” he says. “We have to see how it actually plays out.”

One of the largest concerns for executives who manage supply-chain purchasing at hospitals is how to obtain and use clinical data that allow them to choose between competing devices. The goal: improving patient outcomes and avoiding repeat operations known as revisions. As payers turn toward bundled payments, avoiding revisions can also lower costs. Kaiser Permanente and the Cleveland Clinic have each maintained system device registries that can better track how a device performs after implantation.

Government registries in Australia and the United Kingdom were the first to discover that metal-on-metal hip implants were failing at a faster rate than other hip devices. More than 93,000 metal-on-metal hip implants sold by Johnson & Johnson's DePuy Orthopaedics unit were later recalled, which led not only to revisions but also to thousands of lawsuits.

In addition, the number of recalls in recent years may have caused a splinter in the relationships between physicians and manufacturers.

“There have been disappointments for physicians,” Lerner says. “We've had high-profile recalls. You have this gigantic problem with metal-on-metal implants, which makes a huge impact. That's massive, and I think it undermines that complete trust bond between the surgeons and the companies.”

**TAKEAWAY:** Reducing the number of vendors and developing new ventures are among the ways hospitals are targeting supply-chain costs.

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